

EXPLORATIONS IN MENTAL HEALTH

Trauma, Survival and Resilience in War Zones

The psychological impact of war in
Sierra Leone and beyond

David A. Winter, Rachel Brown,
Stephanie Goins and Clare Mason

Trauma, Survival and Resilience in War Zones

This book, based upon a series of psychological research studies, examines Sierra Leone as a case study of a constructivist and narrative perspective on psychological responses to warfare, telling the stories of a range of survivors of the civil war. The authors explore previous research on psychological responses to warfare while providing background information on the Sierra Leone civil war and its context.

Chapters consider particular groups of survivors, including former child soldiers, as well as amputee footballers, mental health service users and providers, and refugees. Implications of the themes emerging from this research are considered with respect to how new understandings can inform current models of trauma and work with its survivors. Amongst the issues concerned will be post-traumatic stress and post-traumatic growth; resilience; mental health service provision; perpetration of atrocities; and forgiveness. The book also provides a critical consideration of the appropriateness of the use of Western concepts and methods in an African context.

Drawing upon psychological theory and rich narrative research, *Trauma, Survival and Resilience in War Zones* will appeal to researchers and academics in the field of clinical psychology, as well as those studying post-war conflict zones.

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Asking questions will enable one to find the right answer.

Mende proverb

Preface

The West African country of Sierra Leone is a land of marked contrasts. Its Muslim and Christian communities live in harmony, but it has experienced eleven years of brutal civil war. It has breathtaking beauty and natural resources, but these, in the form of 'blood diamonds', have brought not wealth but terror and poverty to many of its population. Its children have heart-warming smiles, but have been both victims and perpetrators of unimaginable horror. Its capital, Freetown, was a home for freed slaves, but those of its citizens who express themselves in ways which do not fit in with dominant societal ideals may find themselves kept in chains.

This book has arisen from each of us having been profoundly affected by our encounters with survivors of Sierra Leone's civil war in the course of research, teaching, clinical practice and/or friendship. We have been particularly struck by the resilience of the people of a country that seems to have had much more than its fair share of tribulation and that, as we have been writing the book, has been undergoing yet more suffering due to the Ebola epidemic. In the following pages, we shall attempt to do justice to, and learn from, the stories of these extraordinary people. Based on a series of psychological research studies, Sierra Leone will be used as a case study of a constructivist and narrative perspective on psychological responses to warfare.

The first section of the book will provide a background to previous theoretical perspectives and research on psychological responses to warfare, as well as to the people of Sierra Leone and the civil war that ravaged their country and its context. In the second section, we shall present the stories of a range of survivors of the war, including former child soldiers, amputee footballers, mental health service users and providers, and refugees. These individuals' stories will be told largely in their own words, using data gathered with a range of qualitative and quantitative research methods. In the final section, implications of the themes emerging from these stories will be considered with respect to how new understandings can inform current models of trauma and work with its survivors. Amongst the issues concerned will be post-traumatic stress and post-traumatic growth, resilience, mental health service provision, perpetration of atrocities and

forgiveness. There will also be critical consideration of the appropriateness of the use of Western concepts and methods in an African context.

We are enormously indebted to the people of Sierra Leone who willingly and generously shared their stories with us. It is impossible for us to mention all of those who have contributed in one way or another to the work reported in this book, but we each wish to make a few particular acknowledgements, and to apologize to those whom we have failed to include, and in several cases whose names we do not know. These acknowledgements are as follows.

David: I wish to express my gratitude to Aneurin Braimah, Susan Bridi, Dr Sulaiman Kabba, Funmi Ladeinde, Dr Sarah Maclean, Dr Edward Nahim, Dr Louise Scrivener, Dr Josefin Sundin, Silvia Urbano Giral, Heleen van den Brink, Dr Nick Wood, the Sierra Leone Single-Leg Amputee Football Club and other amputee footballers who contributed to the research, and to fellow members of the Barnet, Enfield and Haringey Sierra Leone Project Implementation Group, in particular Dr Ros Furlong, Dr Denny Grant and Norma Johnson. I also wish to thank my coauthors for agreeing so readily to join me in this venture, and for doing so with such dedication.

Rachel: I was privileged to have heard the stories told within this research, and I wish to acknowledge the participants who allowed me to step momentarily into their lives; I have been irrevocably changed by their stories. I would also like to acknowledge the contributions of Dr Saskia Keville and Dr Nick Wood, who played a key role in supervising, alongside Professor David Winter, the research described in Chapter 8. I also wish to offer my heartfelt thanks to Aminata Mansaray and Sarah Jones for patiently sharing with me their experience and local knowledge of Sierra Leone.

Stephanie: The people of Sierra Leone won my heart and my admiration with their welcome, their warmth and their resilience. I am particularly grateful for my translator, who provided tremendous insight into the psyche of Sierra Leone people and the challenges they faced with post-war recovery. I want to thank my husband, J., who has always been supportive of my passion and work. And last, I would like to thank Dr David Winter, who convinced me that my work in Sierra Leone was a story that should be told.

Clare: I would like to express my heartfelt thanks to the survivors of the Sierra Leone civil war whom I met during the course of this book. Their generosity in sharing personal and often painful stories, and their ability to rebuild troubled lives, remains an inspiration. I would also like to thank Professor David Winter for the opportunity to develop further this area of interest. Finally, warmest thanks must go to my children, Laura, James and Julia, for being the most wonderful of distractions throughout.

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Part I

Background

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A typical encounter in Freetown

One of us (David) was walking to his hotel in Freetown one Sunday when he was greeted with a shout of 'How de body?'¹ by a very smartly dressed man wearing a suit and the extravagant shoes (in this case, perhaps made of crocodile skin) that are popular in Sierra Leone. David returned the greeting ('De body fine!'²), and then did a 'double take' as he became aware that the man looked familiar. The realization then dawned that he was someone, whom we shall call Samuel, who on every one of David's six visits to Freetown had always magically appeared on his first or second day in town, wherever he might be, and had asked to be hired as his 'minder'. Reminders of the legacy of the civil war were never far away in Freetown and its outskirts: occasional skirmishes between opposing political factions; graffiti advertising gangs with names such as Blade Squad, Murder Inc., One Shot Squad, Black Sword, and Terror Squad; and makeshift roadblocks manned (or 'boyed') by youths demanding money, through which one would drive without stopping if one were feeling brave enough. Despite these, and despite the pitch-blackness of the nights, unlit by electricity, David rarely felt any more need of a minder in Freetown than in the English village in which he lives. Nevertheless, he used to give Samuel a few thousand leones³ (and a Star beer on the occasions when he would again suddenly appear in any bar where David happened to be trying to have a quiet drink after a long, hard day) to be his official minder, largely in order to obtain some relief from Samuel's constant insistence on David's need for such protection and his own need for the money with which this would provide him.

While, to be honest, David generally found Samuel's chatter tiresome and tried to avoid him, this Sunday was different, as David was curious about the dramatic change in his appearance from the rather disreputable-looking character with whom he was more familiar. David therefore asked why he was dressed so well, and he said that he did this every Sunday in order to go to church and obtain forgiveness from God for what he had done in the war. David's curiosity was further aroused, and they agreed to continue the conversation the next day. It went like this:

Samuel: The war normally it has affected many Sierra Leoneans. And then the ones like me they forced me to fight in the war. And then when when

4 Background

I'm fighting the war I do much killing and then the rebels, Kamajor,⁴ and then the rebels and the SLA⁵ and . . . then they're killing each other and then by the end they asked us to come together and then finish with the war. By then there was big trouble . . . because there was more more, more killing more, more, more catastrophe many, many, many problems in Sierra Leone people don't have nothing to eat, people are eating dogs, many people to be crazy, locked up, getting mad, many, many.

David: How old were you when they forced you to fight?

Samuel: I was just 11, 12 years and a half.

David: What happened?

Samuel: Well, they catch me in the village in a raid during the night the rebels and then they catch the young girls and young boys; they say you must join us and then they forced them into sexual abuse the ladies, the young girls, take them to the forest. They say if you don't go with us we kill you. And they give me gun, give my colleagues gun, basically we join them.

David: And what did they force you to do?

Samuel: They forced me to fire, they say to attack ECOMOG,⁶ Nigerian soldiers, we must launch attack, we must fight against them, they are enemies.

David: So you were using the gun when you were 12?

Samuel: Yes, I was using the gun, they gave me the biggest gun to carry. I was a young boy and they forced me to shoot and I killed.

David: How many did you kill?

Samuel: Many, many people, maybe 50, maybe 100 people I killed. I saved my parents because when I fight none of them die but we suffered because we don't have nothing to eat.

David: People who know you fought with the rebels, how do they feel about you now?

Samuel: Normally now they think I've changed because I'm trying to get my family, I have my baby, and I get my wife, so they think I've changed and then I used to go to church because I want to be a godly man. I used to go to church every Sunday.

David: During the war how, how did you feel about yourself?

Samuel: During the war, because they give me drugs I was very nasty but now I appreciate the way I feel because I feel good and Sierra Leone is peaceful so we need help from the outside world to help us so Sierra Leone can be a good place.

Samuel's story encapsulates much of the experience of living in Sierra Leone, and in other countries in post-conflict situations. First, one never knows whether the affable façade with which one is presented conceals a darker past. Literally, one never knows whether the hand that one is shaking may have taken many

lives (in the case of Samuel, probably more than the 50 to 100 to which he admitted) or inflicted unspeakable atrocities. Indeed, victims of such atrocities may find themselves in daily contact in their communities with the perpetrators of these.

Also apparent is some of the confusion that was experienced in a conflict in which various different groups (e.g. rebels, Kamajors, the SLA and ECOMOG) were killing each other, and in which some of this killing was done by children, who were often faced with a choice between killing and being killed. As in Samuel's case, a degree of self-esteem could be maintained by viewing one's actions as having been carried out under duress or the influence of drugs. His account also reveals a desire to move on to a more peaceful life, both for himself and his country, albeit, as is repeated again and again in the stories of war survivors, with a need for outside help. In addition, it indicates that others have been unable to show the same resilience but instead may find themselves locked up and 'crazy'.

All of these trajectories will be evident in the accounts that we shall present, but first we shall review the literature on the psychological effects of warfare and provide more of a background to the situation in Sierra Leone.

Notes

- 1 How's the body?
- 2 The body's fine!
- 3 1 English pound = approximately 6,400 leones.
- 4 Originally secret society members, with supposed supernatural powers, who fought as a civil defence group in the civil war.
- 5 Sierra Leone Army.
- 6 Economic Community of West African States Monitoring Group.

Psychological responses to warfare

Warfare has been taking place across the world for an inordinate number of years. Widespread death and injury inevitably result. For both combatants and civilians, war presents numerous traumatic experiences. Traumatic events can threaten an individual's perception of self and the world. Because much of psychology's knowledge of the impact of trauma stems from individuals seeking help, it has often been assumed that a pathological response is the most common. In reality, the majority of people are resilient to trauma and continue to live emotionally positive and fully functioning lives. This is not to underestimate the very severe difficulties of those who develop post-traumatic stress disorder; rather, it recognizes that not everyone reacts to trauma in the same way. Why some individuals demonstrate resilience, others progress to post-traumatic growth, whilst yet others are affected by post-traumatic stress disorder is a reflection of the heterogeneity and uniqueness of life experiences. It is, therefore, imperative to be sensitive to the cultural context of the individuals and situations concerned. This chapter provides an overview of relevant literature, highlighting the most salient issues concerning the psychological responses to warfare.

Resilience in the face of trauma

Initial research into the psychology of traumatic events focused on psychopathological responses (Hobfoll, Mancini, Hall, Canetti & Bonanno, 2011). However, there is now overwhelming evidence that most people respond to trauma with minimal disruption to their overall functioning and, instead, demonstrate resilience (Bonanno, Westphal & Mancini, 2011). According to Masten (2011), resilience can be defined as the capacity to withstand or recover from significant challenges that threaten stability, viability or development. Bonanno, Westphal and Mancini (2011, p. 513) more specifically define it as 'an outcome pattern following a potentially traumatic event (PTE) characterized by a stable trajectory of healthy psychological and physical functioning'. Empirical data led Bonanno (2004) to propose that whilst there is a natural heterogeneity to

the human response, most of this can be captured in a set of four prototypical outcomes. These have been found to be remarkably consistent across a number of studies (Bonanno, 2012):

Prototypical trajectories of adjustment following a PTE (and relative prevalence) (Bonanno, 2004; Bonanno, Westphal & Mancini, 2011).

(i) *Resilience* (35–65%)

Resilience is typified by transient symptoms of minimum impairment followed, relatively soon after the PTE, by a stable trajectory of healthy functioning.

(ii) *Recovery* (15–25%)

Recovery involves initial elevated symptoms with some functional impairment, followed by a gradual return to normal levels of functioning.

(iii) *Chronic Distress (Post-Traumatic Stress Disorder [PTSD])* (5–30%)

PTSD is characterized by a sharp elevation in symptoms and functional impairment that persist for a long time after the PTE.

(iv) *Delayed Distress* (0–15%)

Delayed distress is distinguished by moderate to elevated symptoms soon after the PTE, with a gradual worsening over time.

For many years a resilient response to a PTE was considered atypical, a result of heightened emotional strength or the converse, a complete numbing of emotions. Indeed, the view of the absence of distress and dysfunction as an abnormal reaction continues to persist amongst many of the lay public. Nevertheless, as Masten (2001) maintains, the capacity for resilience lies well within the range of ordinary human capabilities.

Whilst recovery may be considered in alignment with resilience, Bonanno et al. (2011) emphasize a contrasting path. They maintain that individuals experiencing recovery will, by definition, have suffered a level of acute distress before returning to normal functioning. In contrast, resilience is characterized by a minor and transient level of distress, with minimal function disruption.

Factors affecting resilience

As resilience is the prevailing response to a PTE, consideration of influencing factors must reflect the heterogeneity of the individuals and circumstances involved. In their investigation of the roles of demographics, resources and life stress, Bonanno, Galea, Bucciarelli and Vlahov (2007) suggest that no single factor is responsible for resilience. Rather, there is a 'coalescence' of various aspects.

Certain factors, like personality, may be relatively stable over time, whilst others will vary (Hobfoll, 2002).

Personality

Although there is a widespread assumption that personality is responsible for resilience, Bonanno et al. (2011) warn against overestimating its role. Nevertheless, as Bonanno et al. (2011) discuss, in studies that have measured personality both pre- and post-PTE, high scores on perceived control (Ullman & Newcombe, 1999) and resilience trait (Ong, Fullmer-Rowell & Bonanno, 2010) or low scores on negative affectivity (Weems et al., 2010) and ruminative response style (Nolen-Hoeksema & Morrow, 1991) have been associated with enhanced post-event outcomes. Ego strength and optimism (Farber, Schwartz, Schaper, Moonen & McDaniel, 2000) have also been associated with resilience. However, caution must be employed because, as Tennen and Affleck (1999) point out, in studies where personality is measured post-event, apparent personality characteristics may in fact be an outcome of coping with adversity.

Environmental factors

Personality combines with aspects of the individual's environment in facilitating resilience. Of the numerous factors involved, those of social and economic resources have to date received the greatest attention (e.g., Hobfoll, 2002). People who cope well with trauma have often been embedded in a supportive social context (Lepore & Revenson, 2006). This support can take many forms, ranging from emotional to informational, as described by Kaniasty and Norris (2009). Greater social capital, with greater access to social support, leads, in the majority of cases, to resilience in adversity (Saegert, Thompson & Warren, 2001).

Access to economic resources is often associated with resilience, with increased availability correlated with better adjustment (Brewin, Andrews & Valentine, 2000). Unfortunately, it is often the case that PTEs result in a decreased availability of resources (Hobfoll, 2002), which in turn reduces the prevalence of resilience in the affected population (Bonanno et al., 2007). Furthermore, war often occurs during or as a result of a breakdown in civil order, so many of those experiencing it may have previously been subjected to hardship, followed by limited support after the traumatic event.

Previous stressors

There is mixed information regarding previous experience of life stress and its association with resilience (Bonanno et al., 2011). For example, research has linked past and current stress with increased risk of PTSD (Brewin et al.,

2000) and attendant decreased likelihood of resilience (Bonanno et al., 2007). However, Bonanno, Brewin, Kaniasty and LaGreca (2010) and Silverman and LaGreca (2002) have noted that in the case of disasters, prior experience confers a better outcome.

Agency and self-efficacy

Agency and self-efficacy factors have often been associated with resilience (Luthar, 2006). Positive self-esteem protected children (aged 9–13 years) against PTSD following the 9/11 attacks in New York (Lengua, Long, Smith & Meltzoff, 2005). In their study of child soldiers, Betancourt et al. (2010) found that those who had survived rape during captivity had greater confidence than other child soldiers, possibly a reflection of having managed to endure such hardships.

A priori beliefs and worldviews

Children who grow up in a loving and responsive environment are more likely to develop a positive self-image and positive expectations of the future. Such individuals are more likely to be resilient to adversity (Ahmann, 2002; Masten & Coatsworth, 1998).

Faith and spirituality

Whilst established as influential in resilience in general, spirituality holds particular saliency in the context of war and conflict (Crawford, Wright & Masten, 2006). According to Klasen et al. (2010), former child soldiers who demonstrated post-traumatic resilience also declared a greater perceived spiritual support. This may reflect the significance of belief systems in providing coherence and meaning to life in devastating circumstances (Palmeiri, Danetti-Nisim, Galea, Johnson & Hobfoll, 2008; Wright, Masten & Narayan, 2012).

Acculturation skills

For those who move to new cultures as a result of conflict, greater acculturation and language skills are associated with better adaptation and apparent resilience (Wright et al., 2012).

The physical environment

Research on ill health and bereavement has shown that in such adversity, environmental design can promote well-being (Stokols, 1992). Whether this can be extrapolated to promoting resilience is yet to be explored.

Types of resilience

Lepore and Revenson (2006) expand the idea of resilience to trauma by suggesting that the term is often used to capture different concepts. This, they maintain, reflects the complex nature of the construct:

(a) *Recovery*

Lepore and Revenson (2006) take a stance somewhat contrary to Bonanno's (2004) suggestion that for individuals to be described as resilient they must demonstrate either an almost immediate recovery or a complete absence of any negative reactions. Instead, Lepore and Revenson (2006) propose that even those who are slow to resume normal functioning can be described as resilient compared to those who never recover at all.

(b) *Resistance*

Here, Lepore and Revenson (2006) are in line with Bonanno (2004), describing resilience as including those who exhibit normal functioning before, during and after a stressor. However, this form of resilience does not sit well with prevailing psychological or cultural expectations. There has, therefore, been a tendency to pathologize this type of response, despite evidence to the contrary (Wortman & Silver, 1989). Such mistakenness has resulted in the overprescription of unnecessary and inappropriate interventions in resistant individuals.

(c) *Reconfiguration*

Individuals exhibit this type of resilience when they are able to reconfigure their cognitions, beliefs and behaviours in a way that enables them to adapt to traumatic experiences and possibly withstand future traumas (Lepore & Revenson, 2006). Reconfiguration is similar to post-traumatic growth (PTG). However, whereas PTG refers to positive changes, reconfiguration can include both negative and positive changes.

Resilience is a widespread human response to trauma. It is a dynamic process, leading to adaptive outcomes in the face of adversity (Lepore & Revenson, 2006). Resilience is not simply a personality trait, rather it is a multidimensional concept: a product of the individual, his or her life experiences and current life context. Due to its dynamic properties, individuals may experience resilience in some situations but not others. It should be noted that it is often found that the greater the trauma, the greater the resources and will of survivors to continue with their lives (Erbes, 2004).

Whilst resilience is the most prevalent response to trauma, post-traumatic stress disorder (PTSD) has received greater focus in the literature. This is due in part to the initial misconception of resilience as an unusual rather than a common response. More importantly, the potentially destructive nature of PTSD required it to be examined and addressed.

Post-traumatic stress disorder (PTSD)

As far back as the ancient writing of Homer's *Iliad*, the psychological consequences of trauma have been well documented. Despite this, the study of traumatic response is a relatively recent discipline. In the military field, it was long recognized that well-adjusted individuals could develop acute stress symptoms following harrowing events (Shepherd, 2001). Descriptive terms developed included 'shell shock', 'war neurosis' and 'combat fatigue'. It was initially believed that symptoms would dissipate when the individual was removed from conflict (Wilson, 1994). However, studies with veterans of twentieth-century wars, particularly those of the Vietnam War, proved otherwise; that such distress could be a long-lasting disorder. Subsequent work into the impact of other life stressors, such as rape (Burgess & Holmstrom, 1974), together with information from Vietnam veterans, World War II veterans and concentration camp survivors produced the diagnosis of PTSD. This concept of PTSD has done much to assist in the recognition of the needs of survivors, who were previously misunderstood, stigmatized or ignored. In 1980, the American Psychiatric Association (APA) added PTSD to the third edition of its *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*. The most recent version, *DSM-V*, has an extensive description of diagnostic criteria for PTSD, which can be summarized as follows (based on American Psychiatric Association, 2013, pp. 271–72):

- 1 Exposure to actual or threatened death, serious injury or sexual violence.
- 2 Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks, other intense or prolonged psychological distress, or marked physiological reactions to trauma-related stimuli.
- 3 Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one of the following: avoidance of distressing memories, thoughts, feelings or external reminders of the event.
- 4 Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: persistent negative beliefs about the self or the world, a persistent and distorted sense of blame of self or others, persistent negative trauma-related emotions, constricted affect, estrangement from others, a markedly diminished interest in activities or the inability to remember key aspects of the event.
- 5 Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: aggressive behaviour, reckless or self-destructive behaviour, sleep disturbances, hyper-vigilance, exaggerated startle response or concentration problems.

- 6 Duration of the disturbance is more than one month.
- 7 The disturbance causes clinically significant distress or impairment in social, occupational or other areas of functioning.
- 8 The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

In addition to psychological symptoms, there are considerable interpersonal and social consequences. These include an increased divorce rate, difficulties in parenting (which may have greater impact on the child than the war trauma itself) (Dias, Sales, Cardoso & Kleber, 2014; Lambert, Holzer & Hasbun, 2014; Olema, Catani, Ertl, Saile & Neuner, 2014), physical health problems and decreased earning potential (Jordan et al., 1992; Schnurr & Green, 2004; Walker et al., 2003). Cascading socio-emotional and even genetic effects can be observed in subsequent generations of PTSD sufferers (Masten & Narayan, 2012). This highlights the significance of PTSD both to the individual and to society at large.

Prevalence

As mentioned in our discussion of resilience, even though exposure to potentially traumatic events (PTE) is quite common, development of PTSD is rare, with rates varying between populations, as examined by Johnson and Thompson (2008) and Keane, Marshall and Taft (2006).

The general population

In studies in the United States, Kessler, Berglund, Demler, Jin and Walters (2005) found an overall lifetime PTSD prevalence of 6.8 per cent, making it the fifth most common psychiatric condition in the country. In an earlier study where overall prevalence was found to be 7.8 per cent, gender differences were observed, with women (10.4 per cent) more than twice as likely as men (5.0 per cent) to develop PTSD over their lifetime (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). Similar rates and gender splits have been observed in many populations.

Combatants

Military personnel are, unsurprisingly, at high risk of developing PTSD due to their increased exposure to conflict-associated trauma. A major study of Vietnam veterans and civilian comparators showed that 64 per cent of Vietnam veterans were exposed to traumatic events compared to 45 per cent of civilians (Kulka et al., 1990). Unlike many populations, here the gender split was different, with 15 per cent of men and 9 per cent of women meeting PTSD criteria. It is likely that this gender difference reflects the roles women held in the military at the time. In more recent wars, for example the Gulf Wars, PTSD was observed in 4 per cent of men and 9 per cent of women (Wolfe, Brown & Kelley, 1993).

Refugees

As discussed by Johnson and Thompson (2008), high rates of PTSD have been found amongst refugees affected by war trauma. These range from 23.5 per cent (Eytan, Gex-Fabry, Toscani, Deroo & Bovier, 2004) to 65 per cent (Ai, Peterson & Ubelhor, 2002). Turner, Bowie, Dunn, Shapo and Yule (2003) argue that this variation is due to methodology, with self-report measures overestimating prevalence whilst interview techniques indicate lower rates. It must also be remembered that at the point of investigation, many refugees are in the midst of the asylum process and it may assist their case to exaggerate symptoms. Nonetheless, rates are higher than in the general population. This could be due to the extended duration of trauma and the lack of socio-emotional support available to refugees (Mazur, Chahraoui & Bissler, 2014).

Theories of PTSD

According to Brewin & Holmes (2003), early theories fell into three categories:

- **Social cognitive theories** focus on the way trauma breaches existing mental structures and on innate mechanisms for reconciling incompatible information with previous beliefs, e.g., Stress Response Theory (Horowitz, 1976).
- **Conditioning theories** concern learnt associations and avoidance behaviour, e.g., Keane and Barlow (2002).
- **Information processing theories** centre on the encoding, storage and recall of fear-inducing events and their associated stimuli and responses, e.g., Litz and Keane (1989).

These initial theories provided useful insights into PTSD. However, they were restricted by the small amount of data available at the time.

More recently, as Brewin and Holmes (2003) discuss, theories have been developed with a broader scope:

- **Emotional processing theory** elaborates the relationship between PTSD and knowledge available prior to, during and after the trauma. Those with more rigid views would be more vulnerable to PTSD (e.g., Foa & Rothbaum, 1998). Such views could reinforce critical negative schemata involving incompetence and danger underlying PTSD.
- **Dual representation theory** states that pathological responses (e.g., vivid re-experiencing) arise when trauma memories become dissociated from the ordinary memory system, so that two memory systems operate in parallel, with one taking precedence over the other at different times. Recovery involves the transforming of these dissociated memories into ordinary, narrative memories (e.g., van der Kolk & van der Hart, 1991).

- **The cognitive model** draws attention to the PTSD paradox that individuals feel anxious about the future even though the trauma is situated in the past. Ehlers and Clark (2000) proposed that pathological responses to trauma arise when individuals process the traumatic information in a way that produces a sense of current threat. They suggest that there are two principal mechanisms causing this effect – negative appraisal of the trauma, and the nature of the trauma memory itself. Negative appraisal can become increasingly likely according to the thought processes (e.g., ‘mental defeat’) occurring during the trauma.

Criticism of these theories includes their reliance on the Western concept of ‘self’ (Bracken, 1998). It is widely acknowledged that many non-Western cultures devise a sense of self through their societal roles, and therefore Western ideas of PTSD may be less relevant. As trauma not only impacts a person’s beliefs but also affects their social world (Brewin & Holmes, 2003), theories may need to be expanded to embrace this aspect more readily.

Risk factors of PTSD

Despite many people experiencing trauma, the majority will not develop PTSD. The inherent complexity of the disorder means that a single, definitive reason as to why certain individuals develop PTSD cannot be determined. Numerous studies have identified various risk factors that enhance the chances of PTSD. Such is the heterogeneity and reality of life that these factors are most likely to interact in varying degrees to produce a cumulative effect. These are described below, as reviewed by Johnson and Thompson (2008) and Keane, Marshall and Taft (2006).

Preexisting factors

It is important to recognize that a predisposition to exposure to traumatic events and a predisposition to developing PTSD are separate entities that are difficult to separate in research methodologies.

Familial psychopathology. Despite early animal work suggesting a genetic component in sensitivity to environmental stress (Anisman, Grimmer, Irwin, Remington & Sklar, 1979), there is little evidence of a genetic influence on the development of PTSD following combat trauma (Roy-Byrne et al., 2004), although Stein, Jang, Taylor, Vernon and Livesly (2002) suggested that such an association exists in the case of noncombatants experiencing interpersonal violence. A family history of psychopathology predicts a small increase in PTSD, the effect being greater for noncombatants than combatants. Nevertheless, it would appear that, overall, environmental factors have a greater influence than genetic influences.

Demographic factors. It should be noted that these factors may serve as proxies for other issues, such as social burden and life adversity.