



The ‘Trauma’ of War and Violence

On 25 January 1971, Idi Amin and his army seized power in an apparently bloodless coup. Within a few minutes of the announcement on the radio, Kampala’s streets were filled with crowds rejoicing the overthrow of President Milton Obote.¹ A large number of Makerere University students, too, joined in with celebrations in Buganda, having come to resent the violent and increasingly authoritarian nature of Obote’s regime.² The initial optimism of Amin’s coup, however, quickly faded as the realities of his rule became clear.³ In the first year of the new regime, Amin’s forces murdered several thousand Acholi and Langi soldiers suspected of disloyalty.⁴ Soon after, Amin launched his ‘economic war’ against the 50,000 Ugandan Asians in the country, announcing the expulsion of these ‘parasites’ in August 1972.⁵ The following months were characterised by a deteriorating security situation in which Amin’s army and security services were allowed to kill with impunity, filling Uganda’s prisons and torture centres—including the euphemistically named Public Safety Unit (PSU) and State Research Bureau (SRB)—with little or no regard for the law.⁶

Amin was ousted in April 1979 following the invasion from Tanzania of the Uganda National Liberation Front (UNLF) and the Tanzania Peoples’ Defence Force (TPDF).⁷ A series of short regimes followed—Yusuf Lule, Godfrey Binaisa and Paulo Muwanga—each attempting unity, but ultimately flawed in their attempts at reconciliation.⁸ In elections in 1980 that were widely believed to have been rigged, Milton Obote and his Uganda

People's Congress (UPC) returned to power in a regime popularly known as Obote II, pushing Uganda into a civil war that was likely more brutal and entailed more loss of life than had been the case under Amin. In the Luwero Triangle, an area to the north of Kampala, comprising Luwero, Mubende and Mpigi Districts, the government's counter-insurgency operations against Yoweri Museveni's National Resistance Army (NRA) involved massacres, torture, rape and famine.⁹ It has been estimated that over 60% of civilians in the Luwero Triangle lost at least one first-degree relative.¹⁰ As Leopold Tamale, a farmer from Mpigi District, explained to the Commission of Inquiry into Violations of Human Rights in 1989, 'there was no war', only a wanton killing of people.¹¹

Obote was overthrown by Tito Okello and his army in July 1985. Refusing to negotiate with Okello, the NRA continued to fight, capturing Kampala in January 1986. By the time Museveni was sworn in as President on 29 January, Uganda had experienced fifteen years of violence and conflict. It has been estimated that over 600,000 people had been killed or 'disappeared', with a further 1.2 million refugees in neighbouring countries, including over 200,000 in southern Sudan (now South Sudan).¹² The installation of Museveni and his National Resistance Movement (NRM) government was not the end of internal conflict, however. Between 1986 and the early 2000s, violence continued in northern Uganda as the NRA attempted to pacify the remains of Okello's forces and numerous other guerrilla groups formed in response to NRA counter-insurgency operations. In the context of ongoing instability, a number of spirit mediums emerged, including Alice Auma (known also as Alice Lakwena), who with her Holy Spirit Battalion promised to cleanse Uganda, and Joseph Kony and his Lord's Resistance Army (LRA). Kony sought the moral rejuvenation of the Acholi people, becoming increasingly violent after the failure of peace talks with the government and Acholi elders in 1994, attacking many of the civilians he claimed to represent.¹³ Over a million people were displaced either in an attempt to escape the LRA or as a result of counter-insurgency operations in the following years, prompting a major international humanitarian response. This has included emergency relief to internally displaced populations, peacebuilding programmes and, since the late 1990s, an upsurge in psychosocial programmes targeting both civilians and soldiers (particularly child soldiers). Since the early 2000s, humanitarian relief efforts in northern Uganda have come under fierce criticism for both exacerbating violence and undermining democratic processes.¹⁴

Psychiatry has provided a useful language for observers attempting to make sense of this period of Uganda's history, and the at times incomprehensible levels of violence. One of Amin's leading henchmen was Lieutenant Colonel Juma Ali, popularly known by civilians and military personnel as 'General Butabika'. In 1977, John Kibukamusoke, former Professor of Medicine at Mulago Hospital, a founder member of the National Association for Mental Health (NAMH) and one of Amin's personal physicians between 1971 and 1973, described to *The Observer* how Amin was almost certainly suffering from general paralysis of the insane (GPI), something that would explain his 'syndrome of grandiose paranoia', as well as 'hypomania', 'a state of mind in which a rapid succession of widely varying ideas hit the mind and receive oral expression'.¹⁵ Caroline Lamwaka, a journalist who covered the war in northern Uganda, called Alice 'a lunatic prostitute turned witch'.¹⁶ While Kony, lacking a clear political motive and using brutal tactics, has been variously declared 'mad', 'clinically insane', 'psychotic', 'delusional' and 'paranoid schizophrenic'.¹⁷ Indeed, what else but madness to explain yet another case of apparently irrational African violence? What these explanations have lacked, however, is any attention to the ways in which these movements resonated with long-term upheavals and processes, or how brutality and fear could be seen as a rational means of exploiting a key resource—people.¹⁸ A longer-term perspective, moreover, also raises questions about the legacies of a colonial state that legitimised the use of violence and which, in preparing for decolonisation, rapidly promoted soldiers and police officers through the policy of Africanisation.¹⁹

More pervasive than labels given to leaders, however, has been the use of psychiatric and psychologised language to define and describe populations 'traumatised' by violence. The civil war of the early 1980s, and the violence that continued in the north into the 1990s, coincided with a resurgence of interest in 'trauma' in Europe and the USA. In the USA, where Post-Traumatic Stress Disorder (PTSD) entered the Diagnostic and Statistical Manual of Mental Disorders III (DSM-III) in 1980, it was closely linked to the context of the Vietnam War. In Europe, it was tied to the 'collective remembering' of the Second World War, and particularly the Holocaust, with notions of 'collective trauma' being reborn in subsequent generations.²⁰ 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 on the psychological effects of war and violence in Africa. This focused at first on refugees and children

rather than the broader population—two groups who could be regarded unambiguously as ‘victims’ in a conflict in which there were no clear ‘sides’. It also did not elicit much by way of an immediate response from psychiatrists or humanitarian relief organisations. Barbara Harrell-Bond recalled the ‘stiff resistance’ of non-governmental organisations (NGOs) in northern Uganda and southern Sudan in the 1980s towards ‘basic socio-psychological research’ among refugee populations and little interest in ‘designing interventions to mitigate the stresses associated with their experiences—violence, death and bereavement, uprooting, flight of the challenges of survival and adaptation in exile’.²¹ By the late 1990s, however, psychosocial programmes, notably peer counselling, were occupying an increasingly important space within NGO and humanitarian activities, boosted by an upsurge of humanitarian activity following the Rwandan genocide in 1994, and the declaration of violence as a global public health issue by the World Health Organization (WHO) in 1996.²² In 1998, the Uganda Government and UNICEF conducted a Northern Uganda Psycho-Social Needs Assessment, explaining that the population of Acholi, especially children, had witnessed ‘psychologically wounding events’. An analysis of the psychological effects of war was deemed pertinent because the war had ‘broken down the very fabric of civil society’, and ‘traditional customs which brought community people together to discuss problems and implement solutions jointly are no longer followed’.²³ In line with seeing violence as a public health issue, many of the subsequent programmes have been based on an underlying assumption that without help, traumatic experiences will lead to cycles of further violence.

This chapter, which explores the ‘trauma’ of war and violence in the 1980s and early 1990s, is included in this book because it highlights ways in which the decolonisation of psychiatry remained incomplete. 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 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. In assessments of the psychological effects of war and violence in the 1980s and early 1990s, Uganda’s psychiatrists were largely absent. This is hardly surprising considering that psychiatric

services were on the brink of almost complete collapse after well over a decade of political and economic insecurity. Continuing to offer even the most basic psychiatric services in these conditions took priority over concern about 'trauma'. But this was not without criticism, particularly from a new generation of psychiatrists. In 1992, trainee psychiatrist James Edward Walugembe challenged his colleagues at Mulago Hospital to think about why, despite over twenty-five years of civil war and violence, they were not even thinking about PTSD.²⁴ As Walugembe posited, there was a problem in research on trauma being directed by a range of international 'experts', rather than Ugandan psychiatrists, it being more humanitarian than psychiatric in nature.

DECLINE AND STAGNATION

In February 1971, James Namakajo, formerly a press officer with Obote's Ministry of Information, then a speech-writer to Amin, was arrested and confined in Makindye Military Barracks. Amin claimed, when asked by Ali Mazrui, then Professor of Political Science at Makerere University, that Namakajo had been found on the Fourth Floor of the President's Office with a pistol, intending to kill him. While he was not held in the 'Singapore' cell of Makindye, a place where 'you had no chance of return', Namakajo and his friends feared for his life. Shortly after his confinement, Namakajo recalled, a friend arranged for their father, a doctor, to visit him in Makindye and 'write a recommendation that I was mentally disturbed and take me to Butabika so that I could escape death'. Psychiatry, in this instance, provided a potential means of safety, regarded as superior to conditions within military barracks. The plan failed, but Namakajo was able to secure a transfer to a prison with better conditions shortly after, and was released within a month, his favour having been restored with a temperamental Amin.²⁵

Even if there had been the will among psychiatrists and others to use psychiatry to subvert political action, psychiatry did not have the power to be effective. Between 1972 and 1982, the Ministry of Health's real expenditure per head of population was estimated by the World Bank to have fallen by eighty-five per cent.²⁶ Medical staff fled the country or sought alternative employment in private practice, as salaries eroded under inflation and working conditions deteriorated. By the mid-1980s, Butabika Hospital was operating at a third of capacity (approximately 300 patients), lacking transport, electricity, an adequate water supply

or sewerage system, sufficient staff numbers, money for food or drugs, equipment for the Occupational Rehabilitation Unit, or funds to bury dead bodies outside of hospital grounds.²⁷ In 1987, the World Health Organization (WHO) country representative for Uganda sent a long list of ‘urgent requirements’ to the African Mental Health Action Group. This included emergency relief supplies of drugs, stationery and commodities for patients, rehabilitation of infrastructure, decentralisation and integration of mental health into primary care, recruitment and training of more personnel, provision of books, journals and transport, strategies for monitoring and evaluating mental health services, and ‘a clearly defined mental health policy and programme for the country’.²⁸ As G. G. C. Rwegellera, Lecturer in Psychiatry, remarked in 1986, ‘what is left now is nothing but a shadow of what was once a reasonably good and growing psychiatric care delivery system’.²⁹

The Department of Psychiatry was almost immediately affected by the insecurity of Amin’s regime following his coup in 1971. G. Allen German recalled being asked by the British High Commission to be their daily telephone contact at Makerere University, charged with providing security advice to British families working at the university. ‘No doubt Amin’s forces were monitoring my phone’, German described: ‘I don’t know for sure—but I became aware that I was being followed...I was then detained and accused of being a British spy. Detention was unpleasant but mercifully brief’.³⁰ In the intervening period, all British clinical staff at Makerere Medical School were warned, via a television broadcast, that they ‘had been acting against him [Amin]’ and were advised to leave.³¹ Many of those working in the Department of Psychiatry left in the following months, whether because of the decree expelling Ugandan Asians, or because they feared for their own safety. Lovette Coelho, the Departmental Secretary, was among those forced to leave. German’s wife, moreover, as a Seychellois, was regarded by the Amin regime as Asian, and so, ‘with some anxiety’, German set about making their own preparations. On hearing this news, German recalled, Stephen Bosa attempted to intervene, putting ‘his life and security at risk in so doing. His approaches were rebuffed’.³² By the beginning of 1974, Klaus Minde, John Cox, F. J. Harris, John Orley and Harry Egdell had also left the country, the WHO-funded lectureship was vacant, and Wilson Acuda, who had been studying at the Institute of Psychiatry in London in April 1972, was unable to return due to the political situation.³³ Joseph Muhangi, fearing for his life, followed in 1975 by moving to the

University of Nairobi. Such was the shortage of psychiatrists that Bosa, who was due to retire from government service at the end of 1972, was re-engaged on local contract terms as a Senior Consultant (Psychiatrist) in March 1973 on the personal request of Amin and the Ministry of Health.³⁴

With the exodus of psychiatrists, the National Association for Mental Health (NAMH) and the Mental Health Advisory Committee (MHAC) ceased to exist. At least one new group was formed in their absence, however, using Jinja Hospital as a base. In 1973, Peter Matovu, one of the first Psychiatric Social Workers (PSWs) trained under the scheme devised by Harris, and finally recognised by the Ministry of Health, organised a Busoga Psychiatric Advisory Committee. It included among its members a psychiatrist from Butabika Hospital, physicians and nurses from Jinja Hospital, and representatives from the police, prison, probation service and Church of Uganda. The small mental health clinic at Jinja, established by E. B. Ssekabembe in 1970, provided official justification for the group in a context where any meeting was looked upon with suspicion. Topics included problems of insufficient accommodation for mental patients at Jinja Hospital, severe staff shortages, language problems, as well as the lack of transport for follow-up visits.³⁵ In addition, it sought to continue the mental health promotion activities of the NAMH, publishing articles on mental illness in the *Voice of Uganda*. Ongoing problems caused by stereotypes of the mentally ill were at the fore, not least among members of the Committee itself, who had to be asked not to use outdated terms such as 'lunatic', assume that it was common for patients to pretend to be mentally ill, or that those trying to help might be 'hunted by patients...citing a well known example where this almost happened'.³⁶

Where psychiatry continued at Butabika and Makerere it did so because of the determination of those involved. A. M. Kitumba, who had been in London completing the Diploma in Psychological Medicine (DPM), returned to Uganda after 1972 and replaced J. W. Kasirye as Medical Superintendent of Butabika Hospital. In increasingly trying circumstances, Kitumba and Bosa were left to steer psychiatric services almost single-handedly. Kitumba kept up a regular stream of requests to the Ministry of Health and other government departments for maintenance, repair and improvement works at Butabika, while Bosa, exhibiting his usual stubbornness in the face of difficult circumstances, continued to consult with patients.³⁷ When, due to the absence of transport

and security, staff at Mulago Hospital Mental Health Clinic abandoned their positions, Bosa's response was to camp in the wards with several days' food for the inpatients and himself.³⁸ Such was his determination, according to his eldest son, that one day, 'medical students seeing him walk rather than drive into hospital (he had a house half a kilometer away) cheered him and said "Eh, Professor, you are walking on feet!" to which he replied, "Thank God I am not walking on my head."³⁹ In 1975, Bosa returned to Makerere Medical School to take over teaching in psychiatry, and in 1979 convinced the Ministry of Health to set up a Psychiatric Clinical Officers (PCO) Training School at Butabika Hospital. Bosa returned to Butabika in 1987 to launch the new training programme but here, age and longer-term difficulties with hierarchy reappeared. By 1988, staff at Butabika Hospital complained that Bosa had lost interest in visiting patients and, in their opinion, 'stopped working for the Government years ago'.⁴⁰

The training programmes initiated by Bosa were small in scale if not in ambition. The PCO Training School started with six students, trained in practical and theoretical psychiatry over two years, with the ultimate aim that each district might have at least two PCOs to serve them. By 1988, the school remained 'an improvised one', with no formal building,⁴¹ but had trained a handful of new PCO officers, including Silver K. Kasoro, who was posted to Fort Portal, Kabarole District, in western Uganda.⁴² At Makerere, moreover, Fred N. Kigozi was the first to complete the relaunched MMed in 1979, followed in 1980 by Grace Nakasi, Uganda's first female psychiatrist. In 1981, Emilio Ovuga, from a remote corner of north-western Uganda, completed the MMed but, due to the civil war, immediately left for positions in Kenya and South Africa, only returning to the Department of Psychiatry in 1989.⁴³ Florence Baingana, who submitted a dissertation on patient views of traditional healers in 1987, completed the MMed in 1990.⁴⁴ Having both worked at Butabika since the mid-1980s, Margaret Mungherera and David Basangwa similarly passed the MMed in Psychiatry in 1992 and 1994, respectively.⁴⁵ As a result of the new training schemes, there were five psychiatrists in either government or university service by 1987. With all based in Kampala, the number was inadequate, but was nevertheless essential in preventing the complete collapse of psychiatry in the subsequent decade.

By the late 1980s, the effects of insecurity and financial mismanagement on psychiatry were painfully clear. There had been no renovations to the buildings for over ten years, most of the wards had no mattresses

and were 'in total darkness' at night, and a lack of food meant that Butabika Hospital staff who had not left for better working conditions elsewhere were struggling to feed patients more than once a day.⁴⁶ The hospital remained financially dependent on the Ministry of Health, receiving significantly less than other hospitals, relative to size.⁴⁷ More worrying for the reputation of psychiatry among the general public was the lack of security. Broken locks and windows in the wards, as well as a lack of fencing, meant that only a few hours after admission, relatives were finding their patients roaming the streets of Kampala. In one incident in 1987, a patient walked out of the male admission ward and caused 'grievous damage to a baby in the next village'.⁴⁸ Fears about safety, which had a long history in Uganda, also compounded the low status of psychiatry in relation to other medical disciplines, making it difficult to attract staff. On hearing that he had been asked to take up the position of Medical Superintendent at Butabika in 1987, relieving Kitumba of administrative responsibility, Ben Kawooya recalled how 'Learned friends of mine genuinely tried to persuade me not to move from Mulago to Butabika. One said it was a demotion....Another one burst out laughing and warned me to take care. It wasn't safe what with all those madmen'.⁴⁹

Those in charge of Butabika in the late 1980s and early 1990s argued that 'bias ignorance' against psychiatry and chronic underfunding were preventing psychiatry from recovering.⁵⁰ Yet infighting between those in management roles was likely also exacerbating the situation. A Ministry of Health inspector to Butabika Hospital in 1991 issued a damning report highlighting problems relating to leadership, financial management, staffing, training, patient records and patient care. By this point, the hospital had only three active doctors and a payroll that was heavily bloated by 'ghost workers'—the dead, absentees and fictitious staff who all drew a regular salary. The remaining staff were 'poorly motivated', taking part in 'excessive pilferage [sic.] of hospital property', and demoralised by meagre salaries and poor working conditions. As a result of vandalism during the civil war, there were still no beds for patients, no bedding, drugs, electricity or running water, locks or window panes, or suitable kitchen facilities. Patient services were 'at the brink of collapse', and those at Butabika were now almost completely isolated from Kampala, with the road network destroyed and the hospital transport system 'virtually grounded'. The records system was also non-existent, it not being unusual for patients to be admitted and discharged without

any proper medical records being kept. Yet as the inspector made clear, the situation at Butabika Hospital was ‘not Butabika’s problem alone’, but rather ‘a prototype of what is happening elsewhere’ in general hospitals and clinics.⁵¹ Restructuring and new leadership needed to be at the heart of rehabilitation.

The stagnation and pessimism surrounding psychiatry during the 1980s and early 1990s was reflective of the wider irrelevance of psychiatry within Uganda. In contrast to psychiatry’s involvement in discourses of national development during the 1960s, psychiatrists remained absent from national discussions about economic and social recovery until well into the 1990s. Psychiatry also had little to offer those affected by war and violence. Traditional healing flourished during the 1980s, with only the smallest minority of people exhibiting mental distress eventually reaching Butabika. Into the gap left by psychiatry, however, came a primarily externally driven, donor-funded concern for the psychological effects of war and violence, which has been more humanitarian than psychiatric in practice and delivery, and which privileged the pursuit of knowledge of collective populations.

IN SEARCH OF ‘WAR TRAUMA’

Refugees started crossing the border from Uganda into Sudan in mid-1979, fearing for their physical safety and livelihoods. Numbers were small at first, following the UNLF and the TPDF’s invasion of Uganda. They then grew considerably after the fall of Amin’s regime, particularly when the newly formed NLA prevented national elections in 1980 and launched a war of revenge on the ethnic groups most closely associated with Amin’s government. In March 1982, the number of assisted refugees in settlements and transit camps in southern Sudan was approximately 9000. By September 1983, it had reached 95,000.⁵² The emergency assistance programme launched in response included United Nations High Commissioner for Refugees (UNHCR), the Sudan Government’s office of the Commission for Refugees (COMREF), and numerous NGOs and international voluntary agencies, including Norwegian Church Aid, the Africa Committee for Rehabilitation of Southern Sudan (ACROSS), the Southern Sudan Rehabilitation Assistance Project (SSRAP), OXFAM and Médecins Sans Frontières (MSF). These organisations were little interested in the mental health of African refugees, seeing even basic socio-psychological research

as a neglect of humanitarian duties.⁵³ When a psychiatrist from Juba Hospital, Sudan, approached UNHCR in 1979, stating that those arriving might have special health needs and offering to survey the problem, his offer was declined.⁵⁴ 'Refugees', Harrell-Bond noted following field-work in Yei River District in 1982–1983, 'are expected to cope by being appropriately "social", but they are denied the resources to re-establish the real bases of social life', customs that required money, food and livestock to pay bridewealth, conduct burial rites and host funerals.⁵⁵ In the absence of psychological or psychiatric assistance for individual cases, responses to distress frequently involved either ignoring those who came to their offices, or handing out Valium indiscriminately.⁵⁶ Moses D., a 34-year-old former soldier and prisoner of war, had arrived in Sudan as a refugee in late 1982. He had been tortured and had spent a short period at Butabika Hospital for mental treatment as a result.⁵⁷ Soon after his arrival in Sudan, he sought medical assistance, first at Yei, then at Juba Hospital, where it was decided that he should go to Khartoum for more specialist treatment. The international humanitarian German Medical Team, however, disagreed with this decision and sent him back to his refugee camp. In an attempt to overturn the decision, Moses D. appealed to UNHCR and returned to Juba Hospital and the German Medical Team office. However, now labelled as a 'psychiatric case', he reported being treated as an extreme annoyance: 'I was surprised to see the doctor of GMT [German Medical Team] very angry...He tore the letter of the doctor of the regional hospital to pieces and asked me to leave immediately...When I went they promised to have no more dealings with me'.⁵⁸ Relief workers were poorly trained, and limited resources and time meant there was no incentive for dealing with refugees as individuals.⁵⁹

Harrell-Bond had not set out to conduct research on the mental health problems of refugees. She stressed that she had 'actually resisted facing the possibility that African refugees might share such problems with other refugees about whom I had read', most likely referring to refugees on the Thai-Cambodian border. Yet she also pointed to her 'unrealistic and naive faith in the power of the family system to buffer individuals undergoing stress'—the assumption, reminiscent of colonial psychiatry, that Africans shared common ideas and practices that provided stabilising influences, something that Harrell-Bond called an 'over-socialised concept of man'.⁶⁰ While maintaining that 'economical explanations' were at the heart of much of the 'abnormal social behaviour' she observed in southern Sudan, 'serious attention' to psychosocial

issues was 'long overdue'.⁶¹ On her request, Alex de Waal and Alula Pankhurst, colleagues from the University of Oxford, travelled to southern Sudan in 1984. With three Ugandan colleagues they administered a Present State Examination (PSE), an interview technique that originated in the work of John K. Wing, of the Institute of Psychiatry, London, on how psychiatrists could describe, record and categorise the symptoms of schizophrenia. By the early 1980s, the PSE had been used in numerous cross-cultural studies of mental illness, based on, and also confirming, the dominant assumption in cross-cultural psychiatry that mental illness categories were universal. De Waal and Pankhurst justified their use of the PSE among refugees in southern Sudan by reference to this wider body of collective knowledge, using a modified version of an already 'cross-culturally validated' PSE administered by Orley in Uganda in a study published with Wing in 1979.⁶²

The team conducted at least fifty-seven interviews, which were then analysed by clinical psychologists in Oxford. Of these, three-quarters showed an 'appreciable psychiatric disorder', notably anxiety and depression.⁶³ In contrast to cases of anxiety and depression in Europeans, their respondents presented primarily somatic symptoms, including headaches, aches, exhaustion, sleeplessness and loss of appetite.⁶⁴ The study had some major flaws, recognised by those involved, including a small sample size. More significant was the inexperience of the interview team, which might have meant they had difficulty differentiating between emotional states, or potentially have confused terms for 'depression' and 'annoyance', which in Luganda at least were to a certain extent interchangeable.⁶⁵ The researchers nevertheless concluded that the potential incidence of psychological distress and psychiatric illness was relatively high among refugees in southern Sudan. This did not necessarily mean that psychiatry or counselling was required, but rather represented a call for further research and for humanitarian aid programmes to consider mental health as a priority. The language of PTSD and 'war trauma' had been absent. Instead, they had been concerned more generally with anxiety, depression and stress arising from not only from conflict but from life as a refugee. Through this, Harrell-Bond was making a wider point about the failure of relief workers 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. The irony of administering a PSE to gather 'indirect evidence' for psychological distress among refugees was perhaps lost here.

The use of research to advocate for the development of humanitarian interventions also lay behind the purpose of a series of investigations on war and 'child stress' in 1985–1986. Led by Cole P. Dodge, UNICEF representative in Uganda since 1981, and Magne Raundalen, a Norwegian psychologist, their collaborators included James Lwanga, Lecturer in Psychiatry at Makerere University, Charles Mugisha, a paediatrician at the Nutrition Centre, Makerere University, and Atle Dyregrove, a psychologist with expertise in disaster, grief and stress research. While not formally sponsored by UNICEF, the investigations nevertheless aimed to provide a basis for developing intervention strategies with parents, relief workers, teachers, health professionals and government—'to advocate the children's cause more strongly, especially with regard to their protection during times of war, violence and extreme stress'.⁶⁶ They represented the first investigations into children's reactions to war in Africa, providing opportunities to gain 'more valid knowledge transculturally' through comparisons with studies of children exposed to 'war stress' in Europe during the Second World War, the Yom Kippur war, Cambodia and Northern Ireland.⁶⁷

Due to insecurity across most of the country, the research was limited to the relative safety of Kampala. It comprised four interrelated investigations: the researchers asked 450 13–15-year-olds to write essays on the topics of 'War and violence in my life', 'The story of my life' and 'Events that made me happy and events that made me sad', they conducted 297 interviews of children's experiences of war and collected 40 compositions from 13–18-year-olds during the first week after the coup of 27 July 1985.⁶⁸ A doctor and clinical psychologist also interviewed 79 displaced children from the Luwero Triangle, now living in a Red Cross shelter. The clinical psychologist declared that 80% of these children had signs of depression of which most, unsurprisingly, were 'probably due to the experienced loss of home and close relatives'. Using language that the children themselves may not have used, the researchers described how children spoke of 'running desperately and experiencing extreme anxiety', summarising their descriptions with the word 'horror'.⁶⁹ What was most concerning for the researchers was that most appeared to have 'dissociated themselves from strong emotional responses', describing 'the horrible events without accompanying feelings'.⁷⁰ Basing their conclusions on research on trauma in Europe, this 'growing a shell' was 'a sign of highly traumatized children who have had little or no opportunity of working through emotionally what they have experienced'.⁷¹ Children, along with

refugees and internally displaced populations, were not only relatively accessible populations for research into the psychological effects of war and violence, but represented groups whose suffering could be declared unambiguously. This was particularly the case with children living in the Red Cross shelter. The researchers not only presumed that the children had similar backgrounds which might allow for useful comparisons but, after expressing some concern that their experiences might make them ‘students of war’, stressed that they were, clearly, ‘victims of war’.⁷²

In the years following the civil war of the early 1980s, another group which was able to mobilise international support was that of ‘victims of torture’. The call for assistance had originated with the Nairobi branch of Amnesty International, which had asked two British doctors in 1985 to examine sixteen Ugandans who reported sexual violence, beatings, being burnt, and starvation. One of these, Elizabeth Gordon, a consultant surgeon with ten years experience examining torture victims, stated publicly that ‘I have never seen such gross mutilations as I saw on these Ugandans’.⁷³ In response, the London-based Medical Foundation for the Care of Victims of Torture (now Freedom from Torture) contacted Patrick Bracken, a psychiatrist, and Joan E. Giller, a gynaecologist then working with Karen refugees on the Thai-Burmese border, proposing that they set up a centre offering physical and psychological support for victims of torture in Uganda. The centre was to be based on the model provided by existing centres in London, Canada, Norway, and Denmark, where victims of torture had been subject to medical and psychological investigation and rehabilitation programmes since the early 1980s.⁷⁴ Recalling the request, Giller stressed that she had felt uncomfortable with the ‘assumptions and expectations of being the expert’ in Thailand, knowing little about tropical medicine or work in resource-poor contexts, her very presence having a silencing effect on local knowledge. Uganda, by contrast, seemingly represented something different, ‘a project which seemed, on the face of it, so clear-cut and unambiguous’.⁷⁵ In practice, this was far from the case. First was their location in Kampala, where the team arrived to set up the Medical Foundation (Uganda) in 1987. Like other Kampala-based institutions, this was largely inaccessible to most of the population, and far remote from those areas still affected by conflict. Resentment was already forming against international NGOs who were “‘parachuting in” large numbers of expatriate staff living in relative comfort in Kampala dispensing largess’, with only three of over sixty NGOs in the country working in northern Uganda.⁷⁶ Second, the

category of 'victims of torture' was highly problematic in a context in which most people had witnessed atrocities and were now living in poverty or 'extreme physical hardship'.⁷⁷ To focus on those who had been tortured during periods of detention was to elevate their needs over others, based solely on the agenda of the international organisation providing the funding. The differing expectations of those who did visit the centre quickly made this clear. As Bracken and Giller reflected: people asked for material assistance, basic medication such as drugs for malaria, or work; the only thing 'that no one asked for was any form of psychological assistance'.⁷⁸ To continue to focus their efforts on the centre 'would have been to commit one of the worst crimes of which colonialism, and now neo-colonialism, has been guilty: to undermine local knowledge and local ways of doing things in favour of interventions of often dubious efficacy'.⁷⁹

Abandoning the category of 'torture-victim', Bracken and Giller broadened their work to include psychological and physical support for those affected by violence in the Luwero Triangle but which, in practice, was still shaped by their own interests and expertise. Giller operated a travelling clinic for women who had been raped, offering physical examinations, including an HIV test for those who wanted it, as well as support groups facilitated by a social worker, Stella Kabaganda. In one meeting, a woman exclaimed 'with her arm in the air': 'Who amongst us has not been raped?', and received 'cries of approval' for her call. 'It felt as though a floodgate of emotion had been opened', Giller noted, 'and we were warmly welcomed and encouraged in what we proposed to do'. Yet, as in Kampala, when they brought up the idea of counselling, no one requested it. Instead, 'They wanted advice, medication, practical and financial assistance and reassurance'.⁸⁰ Bracken, meanwhile, turned towards research, undertaking a survey of the psychological effects of violence in the Luwero Triangle. In doing so, Bracken hoped to produce knowledge that would not only shape humanitarian and health worker priorities in Uganda, but would have relevance for humanitarian assistance in conflict and post-conflict settings elsewhere. This included questioning the cross-cultural validity of psychological instruments related to PTSD (which he nevertheless used during his own survey), as well as the assumption that psychotherapy was the most appropriate means of dealing with psychological disturbance relating to war. Not only did Bracken find that 'there was no great increase in severe psychiatric breakdown' and less psychological disturbance than expected, but 'The distress

associated with trauma...[was]...often not conceptualised as a medical problem, and local family networks and traditional healers...[were]...felt to be the appropriate agents to deal with it'.⁸¹

By the time Bracken, Giller and Kabaganda published their first publicly accessible report on their work in 1992, they held up their work with victims of violence in Uganda as a mistake overcome, with lessons to be learned from the original highly centralised approach and the privileging of Western concepts and knowledge about trauma and PTSD.⁸² With Derek Summerfield, Bracken and Giller would go on to present radical critiques of the assumptions underlying the proliferation of programmes providing mental health care for refugees and victims of violence, particularly in developing countries. They criticised the modernist agenda of reducing suffering to standardised measurements, the ethical issues of authenticating a particular type of victimhood and the treatment of 'trauma' as something to be discovered and managed by Western professionals.⁸³ In spite of this, as the number of NGOs and humanitarian agencies grew significantly in Uganda during the 1990s, both in response to the intensification of violence in northern Uganda after 1994, and in the use of Uganda as a base from which to address other conflicts in the Great Lakes region, these criticisms would pass many by.⁸⁴

Research on the psychological effects of war and violence continued into the 1990s, spurred by high-level interest in violence by the UN and the provision of the first significant amounts of funding for research on violence by international organisations. Research in Uganda focused, again, on well-defined and accessible populations, aiming to produce methodologically rigorous data that could be compared with other conflict and post-conflict settings. Refugee camps in northern Uganda and southern Sudan in particular offered a unique opportunity to embark on a long-term research project on psychosocial programmes in post-conflict contexts, with approximately 250,000 Sudanese refugees accessible to the researchers in Moro and Arua Districts.⁸⁵ The camps housing these refugees represented what many assumed (wrongly) to be depoliticised spaces, with no serious attention paid to the ongoing violence of the refugee camps themselves.⁸⁶ From 1991, Uganda was part of a cross-cultural study on the psychosocial and mental health problems of refugees and victims of organised violence, a collaboration between the Netherlands government-funded International Institute for Psychosocial and Socio-Ecological Research (IPSER), the WHO and the World Federation for Mental Health (WFMH). The aim of the study, which

also included Mozambique, Ethiopia, Cambodia and Tibetans in exile in India, was to use simple screening procedures to determine psychological morbidity, investigate the psychological problems encountered by refugees, develop and test training modules and materials for counsellors, to train trainers, and to evaluate all aspects of the project.⁸⁷ In Uganda, not only was psychosocial support required 'from a human point of view', but it was hoped that it would 'stimulate economic reconstruction'.⁸⁸ The activities involved training trainers who had histories as refugees, as well as providing training for twenty counsellors, psychiatric nurses, pastoral workers, medical assistants, female community leaders, primary school teachers and at least seventeen traditional healers.⁸⁹ It was hoped that this would enable those trained 'to recognize children and adults suffering from the consequences of trauma', to provide psychosocial support by setting up self-help groups, and by referring individuals to mental health professionals, where necessary.⁹⁰ According to the project lead, J. T. V. M. de Jong, the psychosocial approach was necessary not because of any conclusions drawn from existing research, but because the scale of suffering meant that it was impossible to address trauma through crisis intervention by psychiatrists and psychologists. Instead, a public mental health approach based on community action was necessary.⁹¹

While Ugandans were trained to conduct research and lead psychosocial support programmes, programmes which they undoubtedly adapted and shaped, research on the psychological effects of war and violence remained in the hands of international organisations and researchers. It was in direct response to this ongoing dominance of international 'expertise' that in 1992, Walugembe, then enrolled on the MMed in Psychiatry, screened new admissions at Mulago Mental Health Clinic for PTSD. While Walugembe argued that more attention needed to be paid to the cultural manifestations of PTSD in Africa, he stressed that the diagnosis was universal. If international researchers were looking for trauma, then it was the duty of Ugandan psychiatrists to at least screen for PTSD, and to conduct their own research into the cross-cultural applicability of the diagnosis. Acknowledging the limitations of his small sample size (100 patients), Walugembe argued that 24% of patients met the DSM-III-R criteria for a diagnosis of PTSD, with a further 11%, who did not meet the criteria, also reporting experiencing a serious traumatic event associated with war. He challenged his colleagues at Mulago to ask why, after over twenty-five years of war and violence, which included 'panda gari' ('pick

me up' detainee screening) operations, psychiatrists at Mulago Mental Health Clinic were not diagnosing cases of PTSD. Yet, he acknowledged, people remained reluctant to visit psychiatrists. For Walugembe, this was not due to the ongoing irrelevance of psychiatry (though that was part of it), but because coping with trauma was something that people turned to traditional healers and their communities for support.⁹²

COPING WITH WAR

Many international visitors to Uganda in the late 1980s and early 1990s arrived with assumptions that they would find whole populations 'traumatised' by war and violence. Amelia Brett, a social worker who visited in March 1991 following a gap of sixteen years, reflected that she had 'expected to find evidence of psychological damage'. What she found, however, 'was the energy, positiveness and will to rebuild shattered lives'.⁹³ Giller, moreover, noted that despite reading widely about Uganda, 'we knew so little about Ugandan people and how they appeared to be coping in the aftermath of tragedy without the aid of therapist or counsellor'.⁹⁴ What emerged from these observations was an intense interest in culturally and socially sanctioned modes of healing which, it was assumed, were playing a vital psychological role. According to Giller, this interest came as a surprise to many Ugandan health and medical practitioners, something she put down to Western medicine having 'instilled a sense of shame with respect to traditional healing', and a legacy of colonialism which had 'undermined any sense of worth in traditional ways of doing things',⁹⁵ but which perhaps also needs to be seen in the context of longer professional struggles for authority in the management of illness and health. Health and medical syllabi were still dominated by Western medical concepts, particularly with regard to psychiatry and psychology, and there was little place for traditional medicine in 'modern' practice.

Accounts of a resurgence of traditional medicine can be found across Uganda and southern Sudan, particularly in light of the decline of health, medical and social welfare systems. Herbalists were active in assisted refugee camps in southern Sudan in the early 1980s, providing, beyond the Valium offered by UNHCR, the only therapeutic option for those with mental illness.⁹⁶ Visitors to the Luwero Triangle in the years after the end of the civil war reported a 'flourishing' of traditional healing, including well-attended and regular healing ceremonies. Traditional

healers, according to Bracken, were 'playing a double role'. Not only were they providing therapy to individuals in a context where the health and medical infrastructure had been destroyed, but they 'functioned as an important link with the past and thus contributed to a sense of continuity in a community which had just endured a very violent onslaught on its way of life'.⁹⁷ Traditional healers reported seeing more cases of *eddalu* (madness), *obusiru* (foolishness) and *akalogojjo* (a mild form of mental illness, characterised by confusion) since the war, but they had also seen increases in a wide range of physical illnesses, something they attributed to poor living conditions and dirty water causing an imbalance in the body. Significantly, in the context of international interest in the topic, they did not recognise a specific category of those suffering from 'war trauma'.⁹⁸

More informal community and church-based networks, where they remained intact, may have provided an alternative form of support. At the opening of a new handpump in Luwero three months after the end of the civil war, teachers and clergy organised several hundred children into an hour-long dance portraying the history of the war, including well-known local incidents and solo performances from children who recounted their own experiences.⁹⁹ In another case, a 45-year-old man, who had had both his hands cut off by soldiers in the Luwero Triangle, was now almost entirely reliant on neighbours for assistance. While he continued to face practical difficulties, he reported that 'the support and solidarity shown...by his neighbours had allowed him to return to a fairly normal life'.¹⁰⁰ In March 1986, a fifteen-year-old girl who had until that point not been able to talk with her parents about being abducted and raped by UNLA soldiers, recounted her experiences in front of a small congregation in a Catholic Church in Nakaseki, Kampala. Regarded as a form of therapeutic cleansing, the girl was committing herself to God, and preparing to become a nun.¹⁰¹ In a transit camp in northern Uganda, moreover, counsellors reported that there were 'almost weekly dancing sessions during which people sing traditional songs, including ones in which they introduce their miserable experiences'. The call of the drums would, according to the counsellors, bring people from all over the camp, with people 'recognizing their clan by the sound of the drums'.¹⁰² As a result of such reports, the organisers of the IPSE-WHO-WFMH collaborative study noted their desire to do more to draw on 'indigenous coping strategies and culturally mediated protective factors'.¹⁰³ Counsellors were already using prayer to conclude group

sessions, but more needed to be done to take ‘a community-based mental health care approach and adapt the methods of counselling taking the context of the local culture into account’.¹⁰⁴

Such accounts of culturally and socially mediated forms of healing and support only reinforce the marginality of the existing psychiatric system. One patient attending Mulago Mental Health Clinic in 1993 was a male soldier from Luwero District, who refused to discuss his combat experience, but described being ambushed by guerrillas, seeing friends killed, and feeling obliged to fight for the rebel side. Having lost all his relatives by the end of the war, he decided to join the regular army, where he subsequently lost his leg. He reported having ‘frequent nightmares related to combat’ and, according to Walugembe, met the clinical definition for PTSD. But the patient did not believe that psychiatry could help him. Instead, he wanted ‘at least a 6 months leave to go and perform the cleansing ritual to get rid of the spirits of the people he had killed, whom he believed were haunting him and keeping him tense and awake all the time’.¹⁰⁵ In a similar case, a sixteen-year-old boy had joined the army after his father was killed by a rebel group and, after months of ‘active combat’, had been injured during a grenade attack on an army lorry he was travelling in. He had been discharged on medical grounds, but despite now having healed physically, he reported difficulties settling back home, as well as frequent nightmares in which he would see friends being killed as well as those people who he had himself killed. In addition to visiting the village health clinic, where he was seen by a medical assistant and Bracken, the former soldier saw a traditional healer. This healer diagnosed him as suffering from the effects of *mayembe* (horned charms), requiring his family to sacrifice a chicken and attend to other rituals. According to Bracken, ‘The young man felt relieved when these had been performed and also felt closer to his family’.¹⁰⁶

We should not assume, however, that community and traditional healers always provided necessary support. In cases of rape, social attitudes, including assumptions about its effects on fertility, made it difficult for many women to talk openly about their experiences.¹⁰⁷ Political considerations and fear also limited the ability of individuals who were otherwise well positioned to offer support, to do so. Teachers, for example, may have been reluctant to show concern for their students because ‘their class rooms contained students from different tribal backgrounds whose parents came from a variety of backgrounds—some from the military and others, supporters of the guerrilla movement’. ‘Severe reprisals’,

as Dodge and Raundalen noted, 'were not uncommon for any one who was even suspected to be sympathetic to one side or the other', meaning it was safest to focus on teaching.¹⁰⁸ Cleansing rituals, moreover, did not always offer the unambiguously positive role purported by observers in the Luwero Triangle. Some elders in Acholi and Madi were unwilling to cleanse returning soldiers at ancestral shrines, 'aware that these young men had killed indiscriminately'.¹⁰⁹ The soldiers, moreover, likely 'had no intention of submitting to the authority of elders, or to a ceremony at which they might be publicly castigated for their behaviour'.¹¹⁰ Alice Lakwena's initiation ceremony, meanwhile, which included placing her hands on the heads of new recruits and cleansing them of past actions, offered a way out of the dilemma of cleansing.¹¹¹

In the context of long histories of war and violence, and in a situation where most were now living in extreme poverty and deprivation, it seems likely that many got by just because they had to. This is perhaps best illustrated by the stories told by street children immediately following the coup in Kampala on 27 July 1985. As one boy recounted:

On Saturday, 27 July, people were running, and I asked 'Why do you run?'

Soldiers started to come, running, shooting up in the air and around.

I thought, the soldiers will enter the market and steal everything. I moved out my bicycle. I started to ride hard. At Queens Way the soldiers were stopping all the cars. I saw a roadblock ahead, many military. They were looting motorcycles, money, watches, everything. I didn't stop. I found a small place where I could pass. They didn't contact me on my bicycle. I rode like a bullet straight home. I found cars breaking down on the way. No number plates. Shooting. When cars fail, people loot tyres, seats, everything.

Stay home, I told my brothers.

On Monday, I found dead people on the way. All shops were empty. For me I was just surviving. I was feeling bad because of the shooting. I came back to the market to help white people find food - you know my job.¹¹²

Such accounts represent anecdotal evidence from children who likely had their own reasons for telling the stories they did to the researchers. But the same can also be said of many other reports of coping, healing and support. Researchers who recorded them had already decided that they were potentially significant forms of knowledge and imbued them with their own assumptions about how individuals and communities were coping.

CONCLUSION

In the context of growing international concern about violence in central Africa during the 1990s, Uganda has occupied an ambiguous space, being relatively peaceful when compared to its neighbours—Democratic Republic of Congo, Rwanda and Sudan. But, in part due to geographical location, being English speaking, and the reputation of Museveni's government for rehabilitation policies, Uganda has also provided a space in which international researchers have felt comfortable, and where humanitarian organisations, looking during the 1990s to move their work beyond the classic emergency response, have been able to expand their ideas about what constitutes a 'crisis', particularly with regard to mental health.¹¹³ Research on depression, anxiety, stress, 'war trauma' and PTSD, conducted in Uganda from the early 1980s, went on to comprise the start of an international body of knowledge about the psychological effects of war and violence in Africa. By the early 2000s, this international body of knowledge and related practices was starting to include psychosocial programmes as essential elements of conflict resolution and peacebuilding. As part of this, leading international humanitarian organisations such as the International Committee of the Red Cross (ICRC) and MSF have prioritised programmes focused on preventing violence and mitigating its effects on health and health care.¹¹⁴ This recognition of violence as a global public health issue, requiring targeted interventions, has a more complex history than that told here in relation to the psychological effects of war and violence in eastern Africa—it also spans concerns about homicide and gun violence in the USA, the recognition of domestic violence and child abuse in Europe and the USA as social issues, and the rise of epidemiology in contexts around the world, among other themes.¹¹⁵ Yet Uganda provided a space for the first research into war-related trauma and distress in Africa—one guided by the interests and priorities of international 'experts'.

The fashion for psychosocial programmes in conflict and post-conflict settings has not been without criticism from psychiatrists, humanitarian practitioners, anthropologists and civil society groups. It has been tied to wider critiques of humanitarianism, in which foreign knowledge has been privileged, conflicts depoliticised and historical contexts ignored, and in which legitimacy has been conferred on a certain type of suffering body.¹¹⁶ Within psychiatry, it has also been influenced by the aims of cross-cultural psychiatry, which has questioned the knowledge-base on

which these programmes have been justified.¹¹⁷ Bracken and Giller, for example, both questioned the idea that trauma existed in a state waiting to be 'found' by an expert, as well as the assumption that those meeting the clinical definition of PTSD would not be able to recover without professional (Western-trained) help.¹¹⁸ More broadly, critiques of psychosocial programmes have centred on their lack of integration into wider health and medical systems, fatigue amongst those targeted by NGOs for support and the lack of regulation regarding approaches. Voluntary Service Overseas (VSO) reportedly ran a psychosocial programme in Uganda in the mid-1990s, involving counselling, but was 'widely criticised for not being integrated in any sustainable public health structure'.¹¹⁹ A participant at a UNHRC and WHO-funded Community-Based Rehabilitation Workshop in Kampala in 1996 suggested that one of the main problems of such programmes was 'too many agencies and lack of proper communication channels'.¹²⁰ In 2000, moreover, Harrell-Bond reported concerns about well-funded agencies in northern Uganda that were working with former child soldiers of the LRA. 'The "therapies" offered', she noted, 'are diverse. For example, some insist on the religious conversion of these children'.¹²¹ This, among one agency, was regarded 'as more important than reuniting children with their parents...in one case at least the parents were not informed for more than a year that their child was safe'.¹²²

As Uganda's psychiatrists remobilised during the 1990s, they became actively involved in projects aimed at providing support to those affected by violence. In the early 1990s, Mungherera established the NGO 'Hope after Rape' for women who had been raped during the insurgency in northern Uganda, to which other psychiatrists also contributed.¹²³ She highlighted the lack of counselling services in northern Uganda, as well as a broader need to help women.¹²⁴ Mungherera also worked as a part-time consultant for the Transcultural Psychosocial Organisation from 1998, ran a mental health service for Sudanese refugees in the Adjumani, Moyo and Arua Districts of northern Uganda and trained psychiatric nurses and counsellors to expand the work.¹²⁵ Nakasi, moreover, became a consultant for the African Centre for the Treatment and Rehabilitation of Torture Victims (ACTV), established in Kampala in 1993 to provide rehabilitation services to survivors of torture.¹²⁶ She worked there until 1998, when her claim that 90% of female inmates in prisons were raped by prison warders led to her dismissal and indictment.¹²⁷ Yet despite this increasing involvement, which since the 2000s has extended to leading

research on trauma, Uganda's psychiatrists have remained largely absent in wider critiques of the methods and approaches used in psychosocial programmes. In the context of ongoing struggles to establish authority over mental illness, claims to the universality of concepts of trauma have remained dominant.

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