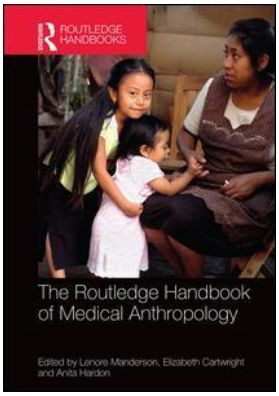

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War, Violence and Social Repair

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Cooperation for Peace and Unity: Rebuilding Health Infrastructure, 2012. Kabul, Afghanistan.

About the photograph

One of my Afghan colleagues, Fatimah, leads a discussion about peace-building. This conference was initiated by a local NGO where I worked as a visiting senior researcher in 2012–2013. Fatimah's session spoke to male and female doctors, elders, midwives, psychologists, teachers, and youth leaders in the health and education sectors. The conference was attended by people of mixed ages, gender, and tribal groups; this particular session was facilitated by an unmarried, professional local woman. The conference and the session were the first of its kind in Afghanistan. "All voices and perspectives are important for our future," Fatimah says.

—Athena Madan

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War, Violence and Social Repair

Lenore Manderson, Elizabeth Cartwright and Anita Hardon

War leaves an indelible imprint on social life, shaking the confidence and trust of those who survive. Civil wars perhaps especially have substantial effects on interpersonal relationships, since there are few options to externalize the responsibility for the perpetration of violence. Soldiers and others who support war efforts routinely construct the enemy as the Other, but in civil war, those who instigate terror, raze villages, rape, torture, and wage war may be neighbors or family members, driven by ideological differences, political and economic grievances, structural inequalities, greed for power or anger at their powerlessness. Internationally and within nations, war and other civil violence and terrorism have profound effects on population health and medical care, food supplies, disease transmission, and the health of health providers, civilians, and soldiers. This has become a growing field of interest and urgency for medical anthropologists.

This urgency is underscored by the continued scale of violence and terror worldwide. The two world wars of the twentieth century resulted in vast loss of life and massive social and economic disruption, and both the League of Nations post–World War One and the United Nations post–World War Two were established to work towards world order and social justice and to find ways to defuse and contain political tensions and address the social and economic forces implicated in them.[1] But war has not abated. At time of this writing—mid-2015—there were around 50 serious conflicts worldwide, of which a number, such as in Palestine (from 1948), Southern Philippines (from 1969 to the present), and Afghanistan (from 1978) have continued for decades: everyday life for people living in these areas is characterized by chronic militarization. Further, some wars—in Iraq, Syria, and Nigeria (Boko Haram)—have escalated in recent years, now contributing to the highest death tolls per annum. Other wars, shocking in their brutality, have moved the setting—the 'theater' of war—while continuing to maintain a regime of terror. One example is the war waged by the Lord's Resistance Army, which operated in northern Uganda and South Sudan in the 1990s and is now active primarily in the DRC (Democratic Republic of Congo) and ACR (African Central Republic).

The collateral damage of these wars, and of state-sanctioned structural violence, militarization, systematic terror, and torture in various other countries, is reflected in the staggering numbers of displaced persons globally. The UNHCR (United Nations High Commissioner for Refugees) has estimated that one in every 122 people in the world is displaced (http://www.unhcr.org/558193896.html). At the end of 2014, 59.5 million people had been forcibly displaced, of whom two-thirds were internally displaced and were living within national borders.

Those living in camps are visible as refugees, but the majority of people relocate as individuals or in larger groups to other safer places, moving to live on the edge of cities or to share houses with kin in other regions. Using these UNHCR estimates, in 2014 some 20 million people had fled across borders, but of these, only a proportion are officially registered as asylum seekers or refugees, living in second- or third-country displacement camps, detention centers, and refugee processing centers. Others escape to and reside in new countries without registration as refugees, without papers and without rights, living in constant fear of deportation. Many have lived under these conditions for decades, often—where conflict has been sustained—for generations. The largest refugee camps, including in Kenya, Ethiopia, and Jordan, now function as major, established towns, where medical, psychological, and social problems are compounded by environmental and economic stressors, restrictions on food and water, aid dependency, trauma, and uncertainty.

The Health Effects of War

Under the conditions of civil war and under regimes of terror, and in environments in which there is high risk of personal and property violence, people's health is affected in multiple ways. This creates challenges for the ruling government (and alternative governments) in meeting the health and other needs of civilian populations and the military. The most immediate demand on health services during times of war is the provision of medical and surgical care of people directly affected, depending on the site of war and the modes of violence, through bombing, landmines, road vehicle and aircraft accidents, gunshot wounds, rape and torture, and other specific acts of brutality and execution. In major conflicts, multiple logistic, financial, personnel, and personal challenges interfere with the delivery of emergency and continuing care. Such care is disrupted by systems challenges—the infrastructure and supplies necessary for emergencies and the maintenance of the delivery of basic primary care—and by the difficulties associated with providing rehabilitation, counseling and mental health care for those directly affected, and supporting health care providers dealing with the high mortality rates of soldiers and civilians. These challenges persist despite the translation from ground wars to 'smart' wars, with drones targeting strategic structures rather than people, that purportedly limit the destruction of civilian lives. Even so, most wars fought in the early twenty-first century are not 'smart'; they involve nasty direct assaults on populations and their places of residence.

Given these challenges, international and civil wars and other forms of extreme violence force governments to meet emergency medical needs at considerable cost to population health (see further Chapter 15). Fighting and peace-keeping are expensive. Funds are diverted that might have been used to maintain local health facilities, support primary health care workers, and undertake illness prevention and health promotional activities. Low- and middle-income countries already face endemic problems of poorly maintained facilities, lack of and broken equipment, stock-outs of essential drugs, shortages of doctors and other health workers, and poor quality of care; these problems are magnified in war and discourage people with acute infections and chronic conditions from seeking care.

Frontline health care workers toil under dangerous conditions, often in the line of fire. In her account of a public hospital in Honduras, Adrienne Pine illustrates the pressures on under-resourced nurses as they try to meet the medical and surgical needs of people who have survived stray gunshots, domestic violence, muggings, intentional attempts at homicide, and quotidian threats to their lives from vehicle injuries, infectious disease, and structural violence. All of these things threaten the lives of health care workers as well as their patients, and the families of both, as they struggle in an environment of unparalleled violence.

13.1 Honduras: Practicing Wartime Healing

Adrienne Pine

In 2013, Honduras's homicide rate was the highest in the world at 90.4 per 100,000, approximately 18 times higher than the murder rate in the United States, and 113 times the average of countries like Italy, the Netherlands, Japan and Australia. These statistics are often used to frame discussions of Honduras. But murder rates can obscure the embodied truths of wartime survival, especially in a country not officially at war. If you ask Hondurans today, most of them will tell you they live in a war zone, usually in reference to the ever-present threat of bodily violence. But metaphorical wars declared against drugs, terror and crime in Honduras are also real wars against the poor. Perhaps nowhere is the current state of war in Honduras more evident than in public hospitals. There, health care workers, suffering the violent impact of neoliberal economic policies in the form of lack of supplies, infrastructure and staff, must attend to the survivors of the war on 'the street.' Employees of Honduras' national teaching hospital, Hospital Escuela, refer to their workplace as a 'war hospital.' Underfunded public hospital buildings are in various states of decay, and police and soldiers roam the hallways, sometimes removing patients from their beds for 'interrogation.'

Since 2008—a year before the military coup that overthrew democratically elected president Manuel Zelaya and precipitated a dramatic increase in all forms of violence in Honduras—I have carried out multi-sited fieldwork among nurses on numerous fieldwork trips to the country. Between July 2013 and June 2014, I worked as a visiting professor at the National Autonomous University of Honduras (UNAH) in the capital city Tegucigalpa, where I taught medical anthropology to nursing students and carried out participant-observation fieldwork in the maternal-child section of Hospital Escuela, administered since early 2013 by UNAH. During this period, health care workers carried out numerous labor stoppages. A variety of scandals plagued Hospital Escuela, including violence carried out against family members by private security guards (themselves former soldiers and police officers, products of the Honduran war machine), assaults and kidnappings. At the same time, the hospital was undergoing a dramatic UNAH-led labor restructuring, allegedly in order to address poor workplace discipline. Unions were under attack, and nurses and other workers were subjected to biometric screening on a daily basis, like the newly installed finger-scanning machines that they had to use at the beginning and end of every 8-hour shift.

With each new crisis, a new mechanism of labor control was implemented as a solution. Following the highly publicized kidnapping and 'miraculous' return of a newborn baby girl (following which newspapers announced the baby's name had been changed to 'Milagro'—miracle) from the maternity ward in May 2014, it was announced that security cameras would be installed throughout the entire hospital. While some nurses welcomed the security measure, others theorized that the whole kidnapping had been orchestrated as an excuse for hospital management to control their every move, weakening their ability to care for patients for fear of being sanctioned by an administration that did not understand the nature of war hospital care.

Between crises, nurses and other health care workers still have to contend with the day-to-day reality of working in an (unofficial) war-zone hospital. The implications of this began to become clear to me on my first full day of fieldwork in the Hospital Escuela's pediatric orthopedic ward. Just after the morning shift began at 6 AM, Edith, the charge nurse, instructed me to interview patients and their families. In the main hall, seven children, ages 4 to 16, lay in cage-like iron beds—none of which had functioning guard rails. Most children had casts on. I began to hesitantly ask each one why they were there. Below, I draw on my fieldnotes describing my first interactions with the young patients and their family members.

> I went to talk to the girl . . . who looked to be at least sixteen. I stood next to her, awkward.
> "What happened to you? Did you break a bone?" I asked.
> "(Inaudible)" is what I scribbled in my notes as her response.
> "What did you say?"
> "*Un tiro*" [a bullet] she said with exhaustion, sadness or something similar.

She wore a full leg cast. I asked if the shooting was recent, saying also that her toenail polish, visible through the toe-hole in the cast, was pretty. It was different colors and had designs, looked recently applied but likely before the cast. She had been shot in the knee last Friday. A poor-looking, frail woman, whom I guessed to be her mother, came and began attending to her.

The frail woman asked me something, and I didn't understand right away. She was asking about a wheelchair so she could bathe the girl with a bullet wound to the knee. Useless, I directed my question to a woman who was with a 14-year old boy in traction, with 'Arthrogryposis multiplex congenita' scribbled on the paper at the foot of his bed. She was washing him and I assumed she was an auxiliary nurse but it turned out she was his mother. As Edith had explained to me the previous day, due to staffing shortages (i.e., firings and hiring freezes), jobs that nurses should do were frequently passed on to family members, and mothers were all in charge of washing their own kids now. In either case, she knew the scene better than I did. "You are going to wash her?" she asked the frail lady, who indicated she was indeed planning on washing the girl. The experienced mum said that there was only one wheelchair on the ward and it was too small for the girl.

Also, it was being used by the little boy, Carlitos. Carlitos, dependent on a wheelchair because of his condition (Edith used the term 'eggshell' in explaining it to me), wheeled himself around in his tiny wheelchair, joking and flirting with all the nurses like he owned the place. Edith told me that almost as soon as he left, he'd break something again and be back in.

So, no wheelchair for the quiet bullet-wound girl with pretty toes. "Do you have soap?" the hospital-experienced mother of the boy in traction asked the frail confused mom. The frail mom held up her little bar of soap. I later realized one of the auxiliary nurses sometimes handed out tiny bars from storage to the parents, though really they were expected to bring their own. What you have to do, said the experienced mum, is wash her on the bed, like I'm washing him (demonstrating a basic sponge-bath technique; she was clearly a pro). The frail mom tried washing her daughter for a couple minutes then came back to the experienced mum, asking her directly (instead of addressing me this time) if she had a robe with which she could cover the girl for privacy. "No," she said kindly, but with a tone that indicated to me that it seemed obvious to her, a regular, what this woman—certainly not a regular—should do. "You have to ask for a patient robe to cover her."

A young boy lay in another bed with his left arm and leg in casts. His mother and father, who looked particularly poor and rural, were loving with him. They told me he had been hit by a taxi in Esperanza, Intibucá. They gently moved his limbs about trying to make him more comfortable.

Another cute little girl (under 10, I'd guess) with one arm in a cast was being gently led in by her father to her mother who waited by her bedside. They had hung a pink princess mosquito net over her otherwise prison/military-looking cot. Later, during rounds, Edith explained to me that the girl had been shot at by thieves, who had held up her family while they were in their car in traffic. They taken everything from them, and then shot her in the elbow, as she sat between a parent and her little brother. Just for good measure. The page taped to the foot of her bed read, "Grade III A open fracture left radius." "We are all exposed here," explained Edith. . . .

In the room that was designated for quarantine, with only one bed, sat a boy with a cast on. Edith explained to me that the doctors had been planning to amputate, but God had saved his limb. It was a shotgun accident. The shotgun belonged to his father's friend and it went off accidentally. The same kid, months earlier, had spent five days in a coma, she told me, after getting run over by a car. Edith explained to me that with an *escopetazo* [shotgun wound/attack] the bullets are dirty, and you have to put the victim on antibiotics so they don't get necrosis. "This is the hospital of the poor," she said, "We have to pray to God to take care of them, we have no other choice." This was partially in reference to the fact that the hospital never had the necessary supplies; the *escopetazo* kid's mother was off buying some bandages and medicine. Families almost always need to purchase meds and supplies on their own, and nearly everything is available within walking distance, from drugstores to the funeral homes surrounding the hospital. But often the drugs in question aren't stocked, whereas there always seems to be a good supply of coffins on display. . . .

Edith called me to join the residents (two tall young men with a combined air of importance) and her on rounds. They started with the quiet teenage girl who had been shot in the knee, with the full leg cast on. Edith told me it was a *bala perdida*—a stray gunshot. I felt then, and also later, that this may not have been the whole truth. Or at least that there was much more going on. She seemed profoundly traumatized (in a way that, in this context, a stray bullet didn't sufficiently explain for me). . . .

A handwritten sign on the wall over the boy in the back corner of the 'contaminated' room read "Children are the most important thing in the world; the problem is we can't even take care of the world." Pointing to the boy under the sign, Edith half-whispered to me that he had "RM," hoping I'd understand. Then seeing I didn't, she went ahead and said *retraso mental* [mental retardation]. An Aguazul bottled water truck had run him over.

In the small kids' room, a mother was sitting with her two-year-old child, who had one arm in a cast. Edith asked what had happened to him and the mother replied that he had fallen from a chair. Edith looked at me knowingly and said, "[h]e didn't fall from a chair. That doesn't happen from a fall off a chair."

In subsequent weeks, it became clear that the child injury patterns I observed on my first day of fieldwork were representative and symptomatic of war in Honduras. While there were injuries like those that regularly put me into casts as a child, such as falls from trees, poorly executed acrobatics, and so on, they were a small minority compared to gunshot wounds and car accidents. In Honduras, the frequency of car accidents is tied to neoliberal structural violence; a lack of auto safety regulation and investment in public infrastructure contribute to the increased deadliness of transportation, especially for the poor. And as Edith implied, the results of intimate and domestic violence (which cannot be easily disentangled from the suffering of war) were ever-present.

The Honduran murder rate has increased in a context of impunity for the perpetrators of violent crime (both overtly political and 'general'). So too have survivors. It is rare to meet a Honduran who has not lost a loved one to homicide. Trauma that would likely be diagnosed (if psychiatric care were available to the general population) as PTSD has become a generalizable Honduran societal fact. But PTSD also medicalizes as a *disorder*—as if there should be a normal, orderly way to assimilate the murder of a loved one—forms of violent subjectivation that are much more complex and culturally rooted than the diagnosis implies.

Nurses in every ward of Hospital Escuela provide care to people who are impacted by violence that goes well beyond what might be knowable from simple murder statistics or easily readable symptoms. Most hospital patients (and Hondurans in general) are survivors in multiple literal and metaphorical senses. They survive violent physical attacks. They survive their deceased family members—victims of murder, car accidents, untreated illnesses and other forms of structural violence. They survive hunger, intimate violence and the fear of living with the 'insecurity' that maims their neighbors, family members and friends, and sometimes themselves.

Whatever the immediate symptoms that bring Hondurans to seek care, this context is their reality. It is the daily reality for Honduran nurses as well. As is the case throughout Honduras, an hour in Hospital Escuela does not pass without a conversation about the dangers on the street. And how could it? The primary focus of most Honduran nurses' jobs is caring for people whose bodies are damaged and destroyed by that violence. But the undeclared war in Honduras also impacts nurses' own bodies. They too are robbed at gunpoint; they too lose family members and friends to violence. They too live every day with fear. Indeed, many nurses became leaders in the resistance movement that opposed the 2009 coup, precisely because of the moral authority that their gendered position as healers accorded them and their intimate understanding of the human costs of the post-coup repression and usurpation of democracy.

In 2013–2014, however, the post-coup resistance movement had reverted to a politic of individualized survival and fear in a militarized state. One morning in the pediatric orthopedics ward, Edith sighed and told me that the previous day, two of her nurses had been robbed on the way to work. She had had her wallet stolen on the bus on the way to her shift a few weeks earlier, but she said she was assaulted less frequently than the others, a fact she attributed to her strong Catholic faith. It used to be worse, though, she said. She used to be afraid to walk down the halls of the hospital, because of armed thieves who would attack hospital workers and family members. "Now with the security guards things have gotten a little better," she told me.

The presence of armed security forces in the hospital was a controversial topic among nurses and patient family members. Police and soldiers also regularly patrolled the halls. In an election riddled with fraud, Edith's candidate Xiomara Castro (of the resistance-affiliated LIBRE political party) lost to Juan Orlando Hernández, whose 2013 campaign promise was to further militarize the country in the name of 'security.' Despite her satisfaction with reduced hallway robbery, Edith was aware of the inherent contradictions of the politic of workplace security, and of the huge problems that private armed guards caused for patients and their families—another regular topic of conversation among nurses and family members. Guards arbitrarily refused entry to some family members, and frequently demanded bribes (*pa'l fresco*—a little something for a soda) for the privilege of visiting patients. This led to emotional stress and physical altercations between family members and guards. It also complicated patient care for nurses. Since family members are responsible for providing nearly all supplies, medication and food for patients, there is little that nurses can do to ensure proper care if family members are not permitted to enter.

In April 2014, UNAH administration unveiled a campaign within the hospital to stem corruption. Posters were placed in numerous locations on all floors of the hospital and at the entry gates to the parking lot, controlled by the private security guards. On one version, the word NO hovered over a cartoon image of a guard receiving a bribe. The other contained the same message with blocky cartoons of a series of workers meant to represent a nurse (female), doctor, security guard and office worker (all male).

Despite the violence and corruption, nurses express a determination to care. In my fieldnotes, I recorded a conversation with an auxiliary nurse:

> "If I win the Diario," Leticia began telling me, then backed up. "I mean, I don't really buy tickets, but if I were to win the lottery, I would spend a million on this ward so it would have the latest equipment. The *cunas* [cribs, but applies to the beds used by the bigger kids too] don't have guard rails. They had guard rails but they're all broken," she said. She then told me (in response to my question about it) that sometimes kids have indeed fallen from the beds, "and imagine—their bones are already broken."

Nurses in Honduran public hospitals face a series of interconnected challenges in providing care. In every ward, patients, family members and nurses alike suffer from the war around them. Hondurans' visible physical symptoms as well as other trauma (PTSD) symptoms are so ubiquitous that they are largely invisible. Nurses provide care without supplies or sufficient personnel, in a work context that limits their job security and scope of practice. This results in further violence toward patients that nurses struggle to mitigate. Although they hold a wide range of political views, they uniformly express affection and empathy for—and solidarity with—their patients. They build creative strategies with family members for providing care that neither party can afford. They build relationships with individuals and organizations (often without the knowledge of administrators) to solicit donations of supplies and informational materials. They hustle construction materials and paint to keep their wards functional and even beautiful, thus creating a symbolic refuge from the violence that surrounds and to such a great extent defines their work. And they dream of achieving their ideal practice, through collective struggle or other means.

Studying War and Terror

War undermines the basic conditions of everyday life: that is its purpose. Bombs intentionally target infrastructure essential for communication and commerce—roads, bridges, dams, markets, buildings of cultural significance (temples, churches)—in order to prevent health care and other services from reaching populations, cutting off people's access to markets, and destroying crops, water and sanitation facilities. 'Scorched earth' has a long history as a strategy of war by government military forces, with the aim of destroying assets potentially available to enemy forces, including food sources, industry, communication and transport. The strategy was used against Napoleon in Russia, in the American Civil War, in the Boer War in South Africa, by Stalin against German troops during World War Two, in with toxins as part of its weaponry throughout the so-called Cold Wars of the 1950s–1970s in Southeast Asia. During the Vietnam War, the highly toxic herbicide Agent Orange was used to destroy crops and foliage to expose possible enemy hideouts, and Agent Blue was used on rice fields to deny food to the Viet Cong and to those with whom they were living. Both herbicides had immediate effects on food supplies, leading – as crops were poisoned and destroyed – to hunger and under-nutrition. But in addition, Agent Orange especially has had long-lasting (if contested) effects on population health, with continued high incidences of birth deformity, skin disease and cancer in areas that were saturated with the chemical during the Vietnam War (Uesugi 2015). The health effects of these chemicals persist over generations (Lykes 1994), yet despite public outrage, they have continued to be part of the armament of the military in more recent civil wars in Central America and elsewhere.

Few anthropologists have conducted fieldwork when war has been at its most fierce. Ethics committees are as reluctant as families to support individual anthropologists for reasons of their personal safety, and because of the ethical issues that arise when researchers work in settings where everyday life is precarious and populations are under acute stress. But anthropologists have certainly been present during some wars, and have provided us with nuanced accounts of the impact of violence on health and wellbeing. Our understanding of terror and torture as a vehicle of control, and the threats of greater violence that are embodied in such technologies, owes much to the work of Allen Feldman (1991) in northern Ireland. Carolyn Nordstrom (1977) conducted innovative, multi-sited ethnographic research in Mozambique from 1988 to 1996, documenting the brutality and profiteering but also the resilience and vision of people determined to resolve everyday challenges and to work creatively to rise above the social fissures of society to bring conflict to an end and to work towards a future. Tim Allen, Sverker Finnström and their colleagues (Allen and Vlassenroot 2010; Finnström 2015) all worked during the years of terror of the Lord's Resistance Army in northern Uganda and contiguous territories, and documented everyday life in times of war. Carlos Iván Degregori (2012) provided a chilling description of life lived during the revolutionary war of the Shining Path in Peru, and Kimberley Theidon's discussion of that same conflict highlights the particular toll of this war on women and children (Theidon 2012; 2015). In their efforts to make sense of the continuation of genocidal wars in the second half of the twentieth century, Alex Hinton and colleagues (2002; 2004) have drawn attention to how cultural notions of difference and purification have been used by armies, colonizing governments, dictatorships and civilian populations to justify atrocities against large populations. The accounts on which these anthropologists draw derive from narrative accounts from survivors, and from fieldwork in the aftermath of war, to highlight the corrosivity of violence on the bodies, minds and physical landscapes of survivors, impacting at individual, community and national levels across generations. In doing so, they remind us of the moral obligations of anthropology. By exposing the motivations of genocide, and the indifference of others as it unfolds, Hinton argues that "anthropology can be a spur to action . . . the first step towards combating it" and of helping societies to "determine how to move on" (2002: x–xi). As we demonstrate in this chapter, this same imperative for research applies to all aspects of war and violence, and the particular work of medical anthropologists in this domain.

PTSD and the Medicalization of Horror

Civil wars of the late twentieth and early twenty-first century have characteristically used technologies of terror to force unsympathetic civilians to submit, and, depending on standpoint, to defeat the contested government or to undermine the efforts of insurgents. Civil wars fought in countries such as Angola (officially 1975–2002), Mozambique (1977–1992) and Sierra Leone (1991–2002), for example, which often followed extended wars of independence, have been marked by the common use of summary executions and mass graves, vicious amputations, beheadings and disembowelment, violent rape, and the kidnapping and deployment of young children, invoking indelibly ugly images globally as well as locally. In an article published in *Daedelus*, anthropologists Arthur and Joan Kleinman (1996) argued that the use of photography and particularly of video recordings had commercialized suffering and misfortune: the appropriation of images of suffering for mass entertainment left viewers insensitive to the pain and horror of war and other tragedies, creating a sense of indifference to the causes of such suffering. They were prescient of the extent now that media is deployed, although they failed to anticipate—how could any of us have done so?—how social media has enabled warring factions to extend the reach of terror in contemporary major wars. Consider from the early

twenty-first century especially the video recordings of beheadings, posted on various web pages, by the Taliban in Afghanistan, the Islamic State in Syria, Boko Haram in Nigeria, and other terrorist organizations. The fear is not of the violence generated by these posts alone, but that we all might become inured to them, as we might become inured to drone technology, as 'simply' aspects of 'modern' warfare.

The close exposure to such acts of terror by civilian populations, the management of maimed bodies and corpses by health workers, and the involvement of soldiers in witnessing and sometimes enacting such violence, takes a massive toll on people's mental health. Awareness of the mental health costs of war are not recent, of course. Shell shock, later also referred to as combat stress, was already well described early in the First World War (Jones and Wessely 2014; Myers 1915), as a reaction to horror by men at the scale of carnage and the immediacy of killing and death; soldiers engaged directly with enemy soldiers on battlefields as well as with prisoners of war. Witnessing violence and its concomitant feelings of horror and powerlessness left many people—men, primarily, since men vastly outnumbered women in direct warfare—unable to function; because of this, they faced accusations of malingering, cowardice, weakness and supreme disloyalty.

The psychiatric category of post-traumatic stress disorder (PTSD), as published in *DSM-III* (1980), was developed to diagnose the psychological experiences of people shocked by the trauma of war or other distressing events such as interpersonal violence or its witness, or a traumatic accident. The symptoms were specified to include the persistent recollection of particular events, including intrusive flashbacks, vivid memories, recurring dreams, hyperawareness, sleep disorders, irritability and difficulty concentrating, such that individuals were overwhelmed to the point that they had difficulty managing everyday life (American Psychiatric Association 1980). This classification of PTSD, updated in subsequent versions of the *DSM*, was strongly criticized, partly because of its questionable appropriateness in different contexts (Solomon and Canino 1990), but also because it medicalized and individualized experiences of war and other deeply disturbing events; that is, the application of the label of PTSD treated the embodied reactions to horror and brutality as individual pathology, while the distanciation of others from these same events was represented as normal and functional. From a critical perspective, it seems extraordinary that a functioning human is one who can rationalize and so dismiss something as disturbing as watching a body blown apart or a gang rape, while the responses of those who struggle to find meaning in witnessing such violence are considered pathological. As medical anthropologist Allan Young (1995) argued for Vietnam veterans, PTSD needs to be considered as a cultural construct, rather than as a reflection of the efforts of individuals to find moral meaning in an ugly and deeply contested war.

On the other hand, medicalizing trauma allows people to replace personal psychological distress with a health problem that can be addressed. In writing of war in Sierra Leone, Doug Henry (2006) illustrates how Sierra Leoneans speak of sustained trauma, associated with fears of being murdered and stories of cannibalism that destroyed their ideas of what it means to be human. In his account, existential and physical unease is medicalized and managed as *haypatɛnsi,* a local illness category that translates as 'spoiled heart.' This condition—the bodily expression of constant fear and anxiety, chronic illness and disability, and economic insecurity—is distinct, despite that it borrows its name from hypertension and is treated as if it were hypertension, with people prescribed Inderal (propranolol, a beta-blocker) when the drug is available. The stigma associated with what people do and see in war, their difficulties in making sense of this, and the links between masculinity and soldiering, mean that soldiers are advantaged by not revealing war experiences and by disguising their struggles on return. Alexander Edmonds illustrates what might be at stake were a soldier to admit to PTSD.

13.2 Does Sgt Pearson Have PTSD?

Alexander Edmonds

When I first met Sgt Pearson at a Starbucks in the Army town of Fayetteville, North Carolina, in 2012, he ordered a latte with soy milk.[1] At age 29, with 10 years of military service and four tours of duty in Iraq and Afghanistan behind him, he is what infantrymen sometimes call a 'war dog,' a seasoned soldier. In addition to lactose intolerance—a condition he blames on drinking long life Army milk—he's got 70 percent hearing loss, stress fractures in his feet, and a mostly healed broken shoulder. After work he has to lie down for an hour "just to be able to do anything." He is worried by the prospect of being away from his seven-year-old son during an impending deployment to Afghanistan. He's got "a bit" of agoraphobia, a lot of insomnia, and he said, "nightmares." Then he added thoughtfully: "Not really nightmares because they aren't fictional, just memory replaying."

Does Sgt Pearson also have PTSD, an acronym that has become so widely known that in many countries it is not necessary to write it out? The American Psychiatric Association introduced the term 'post-traumatic stress disorder' in 1980. It has a range of symptoms, including notably the flashbacks or 'memory replaying' that Sgt Pearson mentioned, as well as avoidance and hyperarousal. Though PTSD is also diagnosed in civilians, it has become the most significant mental health problem in combat veterans in the West. It is estimated that around a fifth of the two million American veterans of Iraq and Afghanistan have PTSD. But it is not known how many ultimately will get the disorder since symptoms can develop months or years after exposure to a traumatic event.

When I met Sgt Pearson again in 2013, he had just returned from Afghanistan—his fifth tour of duty. He told me he had been ordered to have a 'PTSD test' by a superior but had not yet done so. The outcome of that test, if he ever gets it, could have major consequences. A 'service-connected' diagnosis of PTSD—a category that recognizes that illness resulted from military service—can confer a substantial disability pension. The US Veterans Affairs Administration (VA) spent around 36 billion dollars on disability compensation in 2010. Yet despite the potential benefits a PTSD diagnosis confers to veterans, many active duty soldiers fear that it would land them a despised job as what Sgt Pearson calls a 'desk jockey' or end their career.

In this section, I reflect on what happened before that 'PTSD test'—why he was ordered to have it and why he did not want to follow this order. I draw on pilot anthropological fieldwork with soldiers who have been in combat and are now stationed back home. Below, I explore soldiers' perspectives on the military and health care institutions that play an important part in their lives post-deployment, and how they come to accept—or reject—clinical interpretations of their problems.

Given all that is at stake with PTSD, not surprisingly the disorder has sparked major controversy. One issue is its prevalence. Humanitarian responses to war and disaster in the developing world now often include mental health services to prevent or treat PTSD. Derek Summerfield (1999: 1460) has argued that such efforts make disaster into a 'mental health emergency writ large' and can weaken collective forms of coping and healing.[2] Others decry the widening range of people being diagnosed with PTSD: victims, perpetrators, and witnesses of violence as well as those who give care to the traumatized and even those who observe traumatic events in the media.

Fassin and Rechtman (2009) counter that the PTSD illness concept is not 'good' or 'bad' in itself, but reflects an altered moral attitude towards the ill or injured person that goes beyond clinical issues. They argue that previously those who suffered from medically unexplained symptoms caused by violence or accident were often suspected of malingering, or else of unconsciously seeking 'secondary gain' (i.e. the benefits that can be gained through illness, such as sympathy, care or disability pensions). The PTSD concept in a sense 'exonerates' the ill person and shifts the 'blame' for illness onto an external event. As a result of the social and material benefits that can follow from its diagnosis, PTSD is—in Rechtman's words—the only kind of psychological disorder "you want to have" (2004: 914).

However, like many active duty soldiers in the US military, Sgt Pearson did not seem to 'want' this diagnosis. Criticism of the overdiagnosis of PTSD has largely focused on civilians or veterans who have left military service. The moral significance and material effects of a PTSD diagnosis are often quite different for soldiers still in the military. In the American Army, there has been rising concern that soldiers with PTSD are not getting expert help. Some studies have found that less than a quarter of soldiers who are "positive for a mental disorder" (as determined by an anonymous survey) ever see a provider (Hoge et al. 2004). Suicide rates have been rising, and outpaced combat deaths for the first time in 2012. In response, clinicians and military leaders have launched major suicide research

studies and an ambitious resilience training program. They have also conducted quantitative studies of 'barriers to care' that seek to understand why so few soldiers seek mental health treatments. One study that found that "negative attitudes towards treatment inversely predict treatment seeking" and concluded, logically enough, that policy should aim "at reducing negative attitudes towards mental health treatment" (Kim et al. 2011: 65)

Ethnographic research can complement such quantitative research by exploring how such negative attitudes are generated or sustained by daily life and institutions. Sgt Pearson has to date never received a mental health diagnosis, but was admitted into an alcohol abuse program some years ago: "Someone in the 25th in Hawaii decided all these guys just needed counselors. So we would meet in a coffee house, or for lunch, like here." Today he says he only has one to two drinks a day—but then scoffs that this is the Army's "official definition of an alcoholic." He was given antidepressants by an Army doctor, but stopped taking them as they made him feel worse, and had "male" side effects. He also saw a social worker "around three times" after his first deployment. He said "she was educated in talking to people, but we had no common experiences." He added, "Things you did there would be unforgiveable here. That weighed on me. I went to talk to a Baptist preacher back home. He was a Vietnam vet." He was also ordered to see a psychologist in Afghanistan, but he stopped seeing him after a couple of sessions. And most recently he received that "command referral" to get a "PTSD test."

It is not entirely clear whether Sgt Pearson has ever voluntarily *sought* or even *received* mental health care. While he did *choose* to see the social worker, preacher, and GP, he was *ordered* to see the psychologist and to have the PTSD test. This mix of choice and coercion in a therapeutic trajectory that took him from medical to psychotherapeutic to pastoral care makes it hard to determine whether he encountered a 'barrier' to mental health care. Recently, the military has tried to destigmatize PTSD, partly to make it unnecessary to *order* soldiers such as Sgt Pearson to see a clinician. For example, military leaders have been using new language to discuss mental health—or what is often now called 'behavioral health.' Some leaders have dropped the D from PTSD since 'disorder' sounds more serious than 'stress.' Others refer to PTSD an 'injury' to emphasize that it was honorably 'earned' during combat.

Sgt Pearson seemed aware of such efforts but was skeptical: "It's like there are two levels [of leadership]. At the higher level there is the liberal voice of the Army that says meet up, help each other. It cares about high suicide rates. They started treating PTSD as if you're, like, a rape victim, using the same treatment. Hopefully it works. But then on the lower level [of the Army] PTSD is really stigmatized."

The soldiers I spoke to mostly belonged to this 'lower level': enlisted men, NCOs, and a few lower-ranking officers. This group—while by no means representative of the enormously diverse Army—seemed to have precisely those 'negative attitudes' identified by quantitative research. It was not that PTSD was a taboo topic for them; it came up frequently in conversation and often in a joking manner. But more serious talk about PTSD often mentioned soldiers 'who get paid for PTSD.' Sgt Pearson said: "These guys on the big bases, who never saw combat and did paperwork. Some of these guys get paid for PTSD. It really bothers me. Some guys I knew I had to stop talking to them, people who faked PTSD." Others went further, claiming that *anyone* who 'got paid for PTSD' didn't really have it. Although several soldiers openly talked about having some of the symptoms that have now become recognizable signs of PTSD in American popular culture—such as hitting the floor in response to a sudden noise—they thought that most of their comrades who 'get paid for PTSD' do not really have the disorder.

The comments of Sgt Pearson and his comrades might conceivably be changed by training and education programs. Yet, I think these soldiers are not uninformed about mental health problems. Rather they also possess some insight into the current institutional and moral climate in which PTSD is diagnosed and lived. While Sgt Pearson did have a few contacts with caregivers, he was largely unhappy with what happened: "Army doctors are biased. If you start saying anything [about a work dispute], they might side with your commander." Civilian norms around patient confidentiality often do not apply to soldiers. For example, a clinician may be obligated to reveal information about clients to their commanding officers. Of course patient confidentiality is never an 'absolute' right and the limits to that right in the military are based partly on common sense concerns around giving weapons to someone with a disorder or who is on medication. Yet military clinicians sometimes have fundamentally competing obligations: to heal patients and to support military operations.

It has been said that the 'true patient' of the military psychiatrist is the Army itself. This professional position can create major ethical dilemmas. During World War I a psychiatrist who found

a case of war neurosis to be false might send his patient back to the front. Today a soldier judged to have 'fake PTSD' would not be sent to a war zone; more likely, steps would be taken to *remove* him from a war zone. Yet the clinician still has unusual power over the soldier-client. 'Withholding' a service-connected diagnosis of PTSD can deny a soldier disability benefits. The high moral and material stakes of PTSD were made evident in recent scandals about the 'downgrading' of PTSD to a pre-existing condition such as a personality disorder. As Kenneth Macleish (2013: 127) points out, questions about overdiagnosis are inevitably bound up with the enormous economic stakes of disability compensation as well as the "weightier moral economy of who bears responsibility for the effects of violence." Many active duty soldiers are simply concerned that a diagnosis of PTSD can harm their career and status as a 'good' soldier who stoically 'sucks up' pain and suffering.

Capt Mulhern said: "Like anyone who has seen a lot of combat, I have a little bit of PTSD." What is a little bit of PTSD? In epidemiology, clinical trials, and disability assessments, disorders are present or absent; they must be counted. Of course there are more or less severe cases. But what Capt Mulhern meant I think was *not* that he had a mild case of PTSD. Rather, he seemed to be getting at ambiguity in the PTSD concept itself. This captain—who seemed to be highly respected by his subordinates—did not see his symptoms as evidence of mental disorder but rather as evidence of being a good soldier. Symptoms such as a violent temper or jumpiness or a tendency to brood were testimony to having served in combat. They reflected an unspoken sentiment that has perhaps taken root in the US since the Vietnam War: combat messes you up a bit. After war it is normal to be a bit abnormal. What defined PTSD as a mental health disorder for these soldiers was not the presence or absence of PTSD symptoms, but rather the official diagnosis and, paradoxically, the disability pension that might come in its wake.

The logic for them seemed to go something like this. Real soldiers—those who've been in combat—have PTSD symptoms by virtue of being real soldiers. But real soldiers don't get *diagnosed* with the disorder because they know that such symptoms are one of many risks of the job. And those who are diagnosed with PTSD cannot be real soldiers because they violate a soldierly ethos by seeking benefits for simply doing what they're paid to do.

This reasoning about illness and malingering was different from that used by clinicians. For clinicians, illness stigma and malingering are problems that are 'external' to the illness itself. Stigma prevents the person who truly has PTSD from getting treatment or benefits he or she deserves. Malingering is a related, but almost inverse problem. Soldiers who fake or exaggerate symptoms, one neuropsychologist told me, hinder his ability to properly measure clinical outcomes, a problem he resolves by administering effort tests to patients. This position of clinicians—logical as it is—is different from that of soldiers who speak with what Sgt Pearson called the second voice of the Army. For these soldiers symptoms are less important than the issue of disability pension. It seems they could not, or would not, divest PTSD of its material and moral significance. Their attitude echoes the generally suspicious stance taken by military clinicians themselves towards soldiers in earlier eras when the discipline was heavily influenced by psychoanalysis and its concept of secondary gain.

Sgt Pearson said he had done "unforgiveable things there." Later he mentioned one incident in Iraq, when he had mistakenly killed civilians by firing a grenade launcher at a farmhouse he thought was occupied by insurgents. He explained, "Killing does affect you. If it doesn't affect you then you are a sociopath. I mean it doesn't affect some people that much, but if it doesn't affect you at all then you're a sociopath."

What he seems to say here is that it is normal for killing to affect you, so why should those affected by killing be seen as mentally ill? Isn't the soldier who is *not* affected at all by killing the one who is ill, a 'sociopath'? These questions are perhaps one reason why he remains ambivalent about clinical care. The clinical encounter can seem to exclude the moral significance of violence—who did what to whom and whether it was justified, honorable, courageous, wrong, or cruel? In some forms of psychotherapy, a goal is to process emotions such as guilt. Yet the therapeutic attitude—it's OK: I sympathize with you now as a suffering patient with a right to heal—might seem to the soldier to fly in the face of what he knows, which is that what happened was terribly wrong.

Paradoxically, the reverse kind of moral dissonance can also happen in treatment: what was normal during combat becomes immoral when confessed to a clinician. Either way, the difference in how violence is morally valued in clinical as opposed to military situations may contribute to the pervasive feeling among soldiers that "you can't understand if you weren't there." It might also be one reason Sgt Pearson preferred to talk with a Baptist preacher who was a Vietnam veteran rather than with a social worker.

I don't know if Sgt Pearson has PTSD and he probably didn't either the last time I spoke with him. He seemed open to the possibility yet was also deeply skeptical: "I can function. I'm truly not sure if I have it. I have changed over the years, but I'm not sure it's PTSD. I don't want to be on meds. I'm not interested in taking a pill because the Army tells me I need to function."

What might appear to be a negative attitude on his part perhaps indicates his uncertainty as to whether the clinician's 'true patient' would be himself—or the Army. But Sgt Pearson seems to also have a kind of disquiet, a more fundamental doubt as to whether intense stress, killing, seeing others die—and other horrors that he views as a normal part of the job—could actually make him ill in the first place.

Sgt. Pearson's experiences are not easily encompassed by the diagnosis of PTSD. And why should they be? No one's life can be reduced to a mental illness category. But PTSD is currently made to do a lot of explanatory 'work.' It can explain why a soldier is having life problems, but explain *away* bad behavior such as stony silence around loved ones. It can determine entitlements to disability pensions, or end a valued career as a professional soldier. It can signify the heroism of self-sacrifice, or the horrors of combat, or simply weakness.

Yet the PTSD diagnosis also leaves unexplained questions that most plague Sgt. Pearson. "Why are (some of) my comrades ill or homeless, and I'm functioning when we both had the same experiences? Isn't it after all normal to feel this way after all I've been through?" And at moments when he is prone to darker thoughts about the war, he also wonders simply "why am I alive and (some of) my enemies dead?"

Perhaps Sgt Pearson has a borderline case. He has some symptoms, but he also functions. Ultimately, whether he has PTSD will be determined not only by past violent events, but by the interpretation of affliction, including his own interpretation. As he moves through different military and health care environments these interpretations will change—and bring new consequences. One task of the anthropologist is to study such a journey: to try to understand what the PTSD description means and what it does for people differently situated in the world.

Notes

1. I use pseudonyms in this article. I draw on pilot fieldwork conducted in Fayetteville, North Carolina. This research is part of a multi-country study of soldiers' reintegration and psychological wellbeing and health after combat, which is funded by the European Research Council.
2. There is also a growing anthropological literature on PTSD and soldiers' combat experiences. See Macleish (2013), and Wool (2013) for excellent ethnographies of US soldiers' bodily experiences, and Finley's (2011) nuanced analysis of PTSD among veterans in the VA system. Allan Young's (1997) now-classic work critically discusses the notion of traumatic memory at the core of PTSD.

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As we have suggested, framing PTSD as a psychiatric condition caused by the inability of a person to make sense of life after a particularly traumatizing event or extended circumstances minimizes the scale of war, displacement or flight, and the multiplicity of events that constitute these. It overlooks too how people relive terror, fear, and insecurity, and how this shapes everyday behaviors and practices, not only among those directly affected, but also among their descendants. In exploring this, Julia Dickson-Gomez (2002) writes of the hyperawareness and persistent social fears that frame how people live their lives in El Salvador, where the memories of the brutality of its most recent war, and the chronicity of poverty and structural violence, have resulted in people being chronically distrustful of neighbors, politicians, and the police. Like Doug Henry (2006) for Sierra Leone, Dickson-Gomez is concerned with the transgenerational effects of this—in terms of social engagement, trust, parenting skills, and children's interactions. PTSD, as it unfolds through generations, is collective, not merely individual. Her image of "the sound of barking dogs," and villagers' rapid retreat into the jungle at this warning, echo with other accounts of a habitus of vigilance among people in places where security is tenuous. Sverker Finnström's poignant example (2015) of the scent of soap in northern Uganda is another example of how people internalize their experiences of living with violence. Structural and physical violence, and the constant threat of reprisal, retaliation, and terror, force people to flee, hide, and modify everyday life to avoid exposure. They are constantly vigilant.

Below, Meagan Wilson illustrates the internalization of risk among people from minority populations who had left Burma (Myanmar) and were living illegally in Thailand. She focuses on Shan women, who have crossed the border into northern Thailand for refuge from violent militarization and economic deprivation. But, without papers, despised and distrusted by local Thai, these women are stripped of autonomy, mobility, agency, and their health. They live and work illegally, suppressing any possible behaviors, speech, or habitus that might render them as vulnerable in these sites as they were in their homelands.

13.3 Life in a State of Fear

Meagan Wilson

Militarization, and the surveillance in and of everyday life that comes with it, force individuals and communities to adopt strategies of self-surveillance to survive physically and emotionally. 'Burmese' (people living in what is known as Myanmar) have lived under the oppressive conditions of militarization for decades. The Department of Psychological Warfare (now closed but long operating), the Military Intelligence spies in tea shops, the conspicuous number of people wearing government uniforms and weaponry in public spaces: these converging actors established an environment of fear and control, particularly in urban and central Burma, such that ordinary citizens were consistently on guard (Skidmore 2004). In rural Burma, however, particularly in the border homelands of ethnic minority groups, the control was direct rather than implied—routine military action against villagers, and the occupation of their lands, led to the regular violation of spaces and bodies. As a result, self-surveillance—being on guard, always—became integral to their everyday life. When Burma moved from military rule to a 'civilian democracy' in 2011, the changing political climate offered optimism and hope. However, armed conflict and economic hardship has continued in the rural border regions, and ethnic minority groups continue to live without stability, safety or security. Because of these conditions, large numbers of people from these various ethnic groups—including the Karen, Karenni, Kachin, Rakhine, Rohingya and Shan—leave for 'a better life' in Thailand. But, as I describe below for Shan women, 'illegal migrants' in northern Thailand must continue to use the same strategies of self-surveillance to ensure their survival.

The migrant women from rural Shan State, with whom I worked in Thailand, had all experienced militarization both directly and indirectly. Their land was confiscated and appropriated for use as a

military base; they were forced to work as human porters and laborers; they were raped and forced to marry members of the Burmese Army; they had inadequate food and health care. To survive the structural and direct violences of militarization, women devised various strategies of self-surveillance and survival action. For instance, families made regular 'runs' to the forest when the Shan State Army (SSA) intelligence advised them that the Burmese Army was approaching their village, taking with them their source of livelihood (buffalo) and enough rice for a few days. Women would retreat to known landmine-free spaces, feeding their families on frogs, rats and bamboo until it was safe to return. If the Burmese Army was too close, strategies such as 'no smoke' (cooking fire) and silence were essential to ensure their invisibility and so their safety. These strategies were often difficult, with hungry young children, screaming babies, the pain of childbirth, and the travel of sounds across long distances in the still forest night.

Self-surveillance strategies were gendered in particular ways. Women mapped out sites of sexual violence. Roads that lead into Shan villages are associated with rape by members of the patrolling Burmese Army, and women always avoided these routes. Shan families sometimes encouraged their sons to join the Buddhist monastery at an early age to avoid 'being taken' by the Burmese or Shan State Armies as soldiers or porters, but for women to escape recruitment as army nurses or wives, their surest strategy was often to leave their homeland. At the same time, many young Shan people envisaged a future in Thailand that was freer, with better economic prospects and enough cash to send remittances home to 'feed the family.' On arrival, they often found that they had lost not gained freedom, as they faced control and surveillance of a different kind. Harassed by Thai government officials, police, civil society, employers and other migrant workers, migrants from Burma needed to re-invoke strategies of self-surveillance in order to survive.

★★★★

Around three million migrant workers live in Thailand, most from Burma and many in Thailand illegally. Thai government policies concerning migrant registration are complicated, time-consuming, expensive for migrants, and vulnerable to fraud. Migrants usually arrive in Thailand with little or no money, or with a debt owed to a broker, and Thai employers often initially pay the worker's permit. This process creates a relationship of debt-bondage, whereby migrants work without pay, often for extended periods, to reimburse their employer what they owe them (and often much more).

Migrants who do not register, who travel outside of the province in which they are permitted to work, or whose employer withholds their registration documents or work permit, are considered by the Thai government to be 'illegal.' They are vulnerable to arrest, detention and deportation. Only two of the women I interviewed, when I worked in north Thailand from 2011 to 2013, were legal migrant workers; the majority had to monitor where they traveled (avoiding known police checkpoints), decide whether or not to leave an abusive employer, to speak always in Thai rather than Shan, to reduce the possibility of their arrest and forced return to Burma. The majority cross the border without papers, and in an unfamiliar environment, with a new language, no understanding of how Thai migration policy works, and vulnerable to arrest and abuse, they go into hiding. Out of hiding, they need to find a way to stay in Thailand without the papers that might help them do so. Yan (pseudonym) explained to me that "one year after you have arrived you need to renew your permit, but if you can't read or write, you do not know that, and the government says you did not renew so you are illegal."

★★★★

In May 2014, the Royal Thai Army launched a coup d'état against the caretaker government in Bangkok, and the Thai military junta established a National Council for Peace and Order (NCPO), which formed the Committee on Solving Migrant Problems (CSMP). 'Problem solving,' in operational terms, means that migrant communities have been more intensely surveyed and controlled. Raids on known 'urban migrant villages' and growing numbers of people from entire villages are being deported back to Burma, injecting a deeper level of fear into the migrant community, increasing a sense of desperateness among them to remain invisible to the Thai Government and to those who act on its behalf (any Thai person in uniform). The strategies they adopt draw upon their home experiences—the negotiation of safe geographical space and the use of silence.

Migrant workers' fears in reaction to Thai police are visceral. As a researcher, I became afraid and nervous around the police, merely from observing migrants' bodily reactions to them. I recalled in my fieldnotes the experience of going through several checkpoints over the course of a 4-hour bus trip to the Thai–Burma border with some Shan migrants—students—with valid papers:

> I was the only person other than the driver to not manage a single moment of sleep on the bus. I had only been in the country a couple of weeks and it was the first trip I had taken to Mae Hong Son Province. The winding roads tracing the jungle-dense mountains induced nausea, and I wondered how the person sitting in front of me managed to nap so easily in between periods of heaving into a plastic bag. But bodies around me, heavy with sleep, were conditioned to rest for periods, and then to awaken with the slowing motion of the bus coming into a checkpoint, quickly shifting from a state of deep exhausted sleep to one of nervousness and panic. As the bus slowed and stationed at the checkpoint, I noticed that my friend Pee Mai was now awake and alert, her legs rapidly twitching up and down, next to mine, the way *soi* dogs move when they are scratching their parasitic wounds. She sat forward on her seat and began biting her nails as the police entered the bus and walked up the narrow aisle toward us. How did they know who was Thai or Shan . . . to miss the first few rows of (Thai) people and come straight to us? My heart was pounding as I made eye contact with one of them. I knew they were wondering what I was doing there, the only *farang* on the bus, sitting with Shan. In my mind I knew I was safe, but somehow my body didn't. I was sweating and my mouth was dry. When the police officer asked for my passport, I fumbled around trying to find it; my panicked hands were not working. When I eventually handed it over, I was repeatedly asked something in Thai that I did not understand and so I could not respond. I was told by friends to always play the 'no Thai language' card with police. My friends answered for me. I was handed back the passport and then it was their turn for an inquisition. The three of us were legally permitted to be in Thailand and to be on that bus. But the fear of the uniform, the gun, the power differential, overwhelmed us all. How on earth would someone without papers—an 'illegal'—feel in that context?

The conditioned response of fear to the military and police among those with whom I worked is so deep and palpable, it entered my world. However, migrant fears are not merely conditioned responses that originate in their home state. Their fears around militarization and surveillance in Thailand are well founded. Human rights abuses by police, military officers and immigration officials against migrants have been well documented, and include rape, murder, extortion, and other forms of violence. The perpetrators of these abuses are rarely held to account by Thai law (Human Rights Watch 2012; Raks Thai Foundation 2011).

Migrant workers devise behaviors that allow them to survive in their 'new' militarized state. Self-imprisonment is a common strategy to avoid police surveillance, especially during the first months of arriving in Thailand, while getting their bearings. At first, my friends told me, "all (official) uniforms look the same" and new arrivals are conditioned to fear uniform: it has the potential to "make us very hungry." When Mae One first arrived in Thailand, she stayed inside the factory where she was employed for two days without eating, because she mistook the factory security guard for a policeman.

Another Shan woman, Mee Mee Naing, was 17 years old when, on reaching the Thai border, she was taken directly to a garment factory. She imprisoned herself within the factory compound for seven years to avoid the police and possible jail, because she was not registered: "I did not dare go outside the factory. I have never seen what a jail in Thailand looks like but I was scared to go. Even if I needed something from outside the factory I asked someone to get it for me."

The 'business' of illegal migration (Andersson 2014) is an important source of income for Thai police and their families, especially when a 'high quota' of fines from 'illegal aliens' is consistently reached. Police corruption is widespread along the Thai–Burma border regions, and migrant workers regularly need to adapt their self-surveillance behaviors according to changing police practices. One woman explained that "because we cannot have bank accounts, we women used to keep our savings in our underwear (bra) but then the police, they realized this and started to do a body search, and take all of our money, so we had to hide it somewhere else." Another participant feared having her savings stolen and explained to me that she would never keep her savings on her body. She worried especially that, if she were in a motorbike accident, police or hospital staff would take it:

"I thought of a place in my room where no one would ever find my money, a very dirty place, no one would ever touch."

Thai police devise ways to increase their illegal migrant 'quotas,' such as by surveying the bodily markers of migrant otherness and apprehending people on that basis. For Burmese women, waist-length hair, pulled back into a ponytail, is a symbol of cultural identity. When Thai police arrest unregistered migrant women, they often reportedly cut women's hair very short to make them easy to identify as 'illegal' should they re-cross the border into Thailand, so that they are more easily re-arrested and fined (Raks Thai 2011). Migrant men are also assessed for physical markers of cultural identity, and so their physical appearance is monitored in public spaces: "When Thai police come and they see the (Shan) men, they will check their arm to see if they have a tattoo. If they have Burmese or Sanskrit letters, they will ask them for money" (Thong Kham).

Government policy, police surveillance and corruption lie at the heart of migrant workers' fear. Shan migrants devise strategies to reduce their contact with authorities and to remain invisible and silent. Migrant workers have less control when it comes to employer surveillance and abuse, often committed with the intention of maintaining control over employees and increasing employee productivity through fear. The emotional impact of employer control on the women I interviewed was disturbing. Win Win described her five years of work at Golden House as ' a troubled life.' She rarely left the worksite and was surveyed whenever she did, in case she tried to leave. She lived in a room with 15 other women in a space that was only about 3 by 4 metres in size, which made negotiating everyday living such as eating, sleeping and showering difficult; it created fear and anxiety for all of them. The living quarters at the factory were extremely dangerous, and Win Win feared she would die of electrocution:

> Sometimes when it was raining, the water would come in. Nobody could sleep. We would have to hug our clothes and pillow and stand up, we could not sit down. Later when the rain stopped we would have to clean and then sleep. Somebody died from electrocution. I was very afraid (of dying) so I went to sleep on the table.

Listening to Win Win's story, I felt claustrophobic and anxious; I wondered how I would ever have the strength to survive five years of living the way she had been forced to live. The everyday suffering she communicated was deeply troubling, but I sensed there was more to her story. Her narrative spun round and round an intrusive character—the boss's son—until she finally explained this to me. He was a rapist. He regularly raped the 'beautiful' women who worked and lived in the factory. "I got this too," said Win Win, "but some women, they got a pregnancy." I witnessed the terror from her past being embodied in the present. She was shaking with fear, while sharing the terror. It was as though her trauma was indelible. But with determination, she articulated her feelings: "Sometimes when the boss's son hurt me, other people saw it (because of the cramped living quarters). I felt ashamed. I thought if I get stressed, it only hurt me more. I cannot do anything to him. I just had to live like that and let things go." Win Win knew of two women who became pregnant following rape, and who had had abortions:

> For one of them, a big stick was brought into the factory to do the abortion there. The other woman, the boss took her to the hospital to do the abortion. They were afraid other people would know about them and what they were doing to people if the women had the babies.

Win Win eventually devised a strategy to escape factory life. She found a husband. She did not love him or even like him, but she could survive on the outside with him. However, the 'troubled feeling' of life at Golden House traveled with her when she finally left. Like many other women I spoke to, Win Win had to negotiate ways to monitor her own mental health and implement strategies to keep emotions in check. All of the women I interviewed had survival strategies that revolved around the notion of *mee sa thi*: to not think too much. *Mee sa thi* requires that a person 'get out of their head' and into their body, to connect with the wider physical world: singing, playing with children, praying to Buddha, smoking a cigarette, chewing betel, laughing at someone or something, admiring a beautiful flower, preparing Shan food. All of these can help a person to *mee sa thi*, avoid reflecting on their 'troubled life' as a migrant worker and their compromised freedom, even more tightly surveyed and controlled in Thailand than in their homeland. Win Win explained: "In Shan State, when there is not civil war, I can go wherever I like all of the time. Civil war does not happen

all of the time. (But) here, when I was working in the factory, if I went outside the boss would send someone to follow us. I think I was happier in Shan State." Kyi also felt happier in Shan State and explained that she needed to monitor her state of mind regularly in Thailand: "I often think, oh I am thinking too much; if I keep thinking back to my life in Burma I cannot be happy. So I try to stop thinking and I calm down a lot."

Migrant women strongly believe that working in Thailand and the suffering that comes with it is essential for the survival of their families back in Burma, and they believe that one day they will be able to return home with enough money for a decent life. In reality, migrant workers often become trapped in a liminal world in Thailand, with no economic means to leave, where dreams of a free future are just dreams. The emotional self-surveillance strategy of *mee sa thi* prevents migrant workers from thinking their dreams through to the point where they actually map them out in the world in concrete terms. If they did, they would realized their dreams are unattainable. Emotional stability would be lost, along with the will to survive.

Acknowledgments

This case study is based on ethnographic fieldwork conducted in Chiang Mai and Tak Provinces, northern Thailand, from 2011 to 2013. A 2011 Prime Ministers Australia Asia Award and a Monash University Australian Postgraduate Award Scholarship supported this research, which was conducted for a PhD. It included 26 in-depth interviews with women, mostly of Shan ethnicity, who had migrated from Burma. All women referred to their homeland as Burma, not Myanmar. I use the term 'Burmese migrants' to refer to all migrants from Burma, not Shan specifically.

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The lives of the women who Wilson describes are circumscribed by structural vulnerability, as we discussed also in Chapter 12. People who lack official residential status of any kind have no rights to health. They are subject to exploitation as workers; they lack secure housing, state education, and social support; and their poverty and the secrecy in which they live lead to health problems. Yet gaining papers comes with a cost. In Chapter 12, we discussed Miriam Ticktin's (2011) work in France, where people can claim ill health as a reason for a continued authorized temporary visa, with the option of legal residency after five years. Cristiana Giordano (2014) provides us with a contrasting example in Italy, where residence is secured from claims of abuse. 'Credible' and recognizable narratives are essential for this, and so women provide the bare facts of their transit from home country to Europe, elaborated by their brokers to authorities as accounts of forced migration, violence, and abuse to ensure new residential status.

Reconciliation and Repair

The aftermath of war necessarily involves not only physical reconstruction but also nation building. War memorials and museums acknowledge the costs of conflict to human life, but in so doing, war often appears to be glorified, the contributions of soldiers and civilians represented as

sacrifices to nation. On the other hand, many museums are built to reinforce peace and human rights. The Holocaust museums in Germany and worldwide have arguably led the way in supporting resistance to war, racialized terror, and assaults on human rights, with a growing number of museums now established, globally, to honor the memories of other people subject to genocide or killed either on the frontline or as 'collateral damage' in other internal and international conflicts. In Berlin the Jewish Museum, the Topography of Terror Museum, the Memorial to the Murdered Jews of Europe, the Roma Holocaust Memorial Pool, the Stolperstein or 'stumbling stones' set into the cobblestone streets of the inner city, all reflect how one city has worked to make sense of its history of terror and brutality. The city has literalized the commitment of its majority population to avoid repetitions of crimes against humanity by reminding its citizens (and visitors) of the past.

Memorials of regret have increasingly been only one way by which countries have sought to redress the wrongs of militarization and terror. Truth and Reconciliation Commissions have been a powerful technology of restorative justice, through which people have been encouraged to speak of wrongs against them, or their role in perpetrating such wrongs, in war and in other violent circumstances, despite the potential risks they take in making public their own subject status (Hayner 2001; Manderson et al. 2015). In Argentina, following the restoration of democracy after seven years of military dictatorship, the National Commission on the Disappearance of Persons (CONADEP) was established with the task of exhuming unmarked graves. In 1986, an NGO, the Argentine Forensic Anthropology Team *(Equipo Argentino de Antropología Forense)* was established to continue this work; it has subsequently worked in many countries to train nationals to exhume bodies and identify human remains as a component of restorative justice. Below, we turn to the aftermath of the Spanish Civil War and the dictatorship that followed, a period of repression that ended only in 1975. Rachel Ceasar considers the symbolic importance to families of the exhumation of bodily remains from mass graves, some 70 years after people disappeared and were presumed to have been lost forever.

13.4 Exhuming the Disappeared

Rachel Carmen Ceasar

New advances in science and technology are increasingly used in post-conflict countries to protect heritage, promote reconciliation, and bring justice to victims of human rights violations. The current exhumation of mass graves in Spain is one example of how everyday citizens negotiate knowledge and memory in the aftermath of conflict, and through exhumation, people seek a sense of justice and peace. But what happens when bodies are exhumed?

For 17 months, I conducted ethnographic fieldwork and explored the archives related to the current exhumation of mass graves that date from the Spanish Civil War (1936–1939) and the Francisco Franco dictatorship (1939–1975). During and after the Civil War, the institutions of Church and political regime went hand in hand: "Religion and the army," explained Luisa of San Pedro, Spain, "were the two pillars of Francoism." People who were suspected of resistance were arrested, interned in concentration camps, and executed; over the course of the war, 130,000 civilians and Republican partisans were killed. Most were buried anonymously in unmarked mass graves, their deaths denied or suppressed by those who lived nearby. Because the Catholic Church had legitimized the Francoist regime, these mass graves of Republican partisans were often located in or around Church cemeteries. For this reason, I spent much of my time in Spain at graveyards in churches.

One night, on her patio, Luisa told me that her father's body was located in an unmarked mass grave in the San Pedro cemetery. Now in her 70s, Luisa grew up knowing that her father had been killed 'for his ideas,' a common way of referring to people with leftist leanings in Spain. Luisa knew

why, but she did not know how or where her father Martín was killed. Exhuming his remains would be testament to his death and evidence of the violence committed against civilians like him, during the Spanish Civil War and subsequently—for a total of 40 years.

"If we ourselves don't know where he is—there's nothing to justify [his death], just bones. Just to think this . . . " Luisa gasped, and let her voice drift into the muggy summer night. "For all that they excavate, I can't say that this [person] is mine. The only thing we have that makes him distinct [from other bodies in the grave] is that in the pueblo, there were few people who wore boots. It's what we have." She showed me a photograph of her father. "It's the only one [photo] we have, and that's because I stole it!"

Luisa, like many daughters of the Civil War period, awaits the discovery of her father. "*Yo tenía mucha falta de mi padre*, I missed my dad a lot—I don't know if that happens to all girls." The boots and the single, spectral photo are provisional placeholders for the missing body—until the exhumation.

Unlike the refugee bodies of asylum seekers in France today, whose identity is authorized by medical expertise (Fassin with d'Halluin 2005), the exhumation of the disappeared in Spain is a collaborative process driven by local and descendant communities, together with archaeologists and local historical memory associations. In Martín's case, Luisa searches for evidence and truth to the specifics of a body—a body that they may never find. In this manner, the corporeality of Martín's absent body is paid homage to by his family and community, because to *not* do so would be to refute the killings of and violence against Republicans during the war and dictatorship.

"All this began because of a genealogical error, because I didn't know how many brothers my grandfather had or what their names were," Ana, Luisa's daughter, explained. Ana was speaking of a common taboo reflected in the genealogies of Spanish families from either side of the war. "What we would like, I suppose, as families of the disappeared, is to find his remains."

Like many Spaniards who grew up at the end of the dictatorship, and so were born in the 1970s, Ana uses the human rights term *desaparecido* or 'disappeared' to refer to her grandfather and other victims killed by the Nationalist Army during the Civil War or under the Francoist dictatorship. This much Ana and Luisa knew: Martín was killed and left in an unmarked grave in the cemetery of San Pedro, an earth so cracked and dry that bones exhumed here pulverized when touched.

When a grave is opened, the context is contingent on the political climate surrounding the exhumations, as well as the sentiments circulating among families hopeful that they will find a body they can claim. Many people were complicit in the oppression under Franco, and even after the war and dictatorship had ended, men like Martín could not be exhumed; the government, the Church and families were silent of their fate.

Until 2000, families were prevented from exhuming and reburying Republicans. The circumstances of the dictatorship and democracy prevented further investigation of the conflict from taking place, eliminating the possibility of a national truth and reconciliation commission. This enforced silence by the government extended to the living as well as the dead. Communities wanting to locate and rebury Republican soldiers and civilians, who had been killed by the Nationalists and their supporters, were discouraged from doing so by the ruling Francoist regime. But in October 2000, over 60 years after the end of the war and 20 years into democracy, the first exhumation of a Republican mass grave took place in Priaranza del Bierzo, Spain, and is considered the first to be conducted by a technical team of archaeological experts. Through the recovery of Republican remains, and the conduct of proper burials for these remains, the exhumations provided Spaniards with an historical alternative to the recent past.

My exchanges with Luisa and Ana inside and outside the graveyard revealed feelings and interests that might seem irrelevant to the larger goals of history that privilege objective knowledge of the past. Yet by approaching the exhumations in San Pedro as another perspective of the past—that of the disappeareds and their descendants—Luisa, Ana, and other descendants of the dead contributed to the exhumation process and played an important role in reframing contemporary Spanish history.

The desire to produce knowledge about the bodies of the disappeared, and for Luisa and Ana to prove Martín's existence, suggests varying (and sometimes conflicting) interests of stakeholders involved in exhuming over 70 years after the war: proper reburial, recognition of victims, a multivocal

perspective of the past, evidence of human rights violations. In addition to the work of archaeologists at the San Pedro exhumation, Ana's genealogical work and Luisa's photos of her father also formed part of exhumation ethos.

"There were two classes of citizens: those who had won the war, and those who had lost. It was like in India—do you know the caste system? It was the same here," Ana explained. "Because of your religion!" added Luisa. Luisa explained that her family were forced to go to church, as was then expected in San Pedro and throughout Spain during the dictatorship. "The losers were segregated [from the war victors]—they didn't even go to the same dances together," Ana added. "It was a Nationalist–Catholic regime, this Catholicism, so everyone went to mass." Catholicism in Spain, the women explained, was not just a religion or part of the regime; it was part of everyday life. During the war, acts of religiosity were an important part of Spanish society—and politics.

The importance to both Luisa and Ana to know Martín by obtaining his body also reflected a Catholic sensibility. Their desire for his physical remains was a kind of *sacramental symbolism*, what anthropologist Joseba Zulaika has described as a "concern with certain limiting concepts having to do with life as a whole, the notion of death included" (2000[1988]: xxv).

In *Basque Violence: Metaphor and Sacrament*, Zulaika examined sacramental symbolism as an analytic to understand the subjective expression of Basque political violence and terrorism in his hometown of Itziar. Zulaika contextualized Basque political violence within the broader cultural and moral framework of Basque nationalism and its sacramental aspects. In the same manner, Luisa's and Ana's desire to find Martín reflected their desire to reclaim his body from a regime, religious institution and ideology that contributed to his death. By doing so, Luisa and Ana aimed to "resacramentalize" (2000[1988]: 48) or reclaim Martín according to their own values and practices.

★★★★

In August 2012, together with members of a local historical memory association, an archaeological team, and other families of the killed, we spent one month searching for Martín and another 200 persons killed in the San Pedro cemetery. Could one of these bodies be Martín? Ana visited the exhumation site where we were working, in a section of the cemetery. This was a section that, during the war, was separated from the sacred Catholic grounds; this was where Republicans were killed and left in unmarked graves.

When one of the graves was finally opened, Ana stepped down into it. Speaking from inside the grave with a cigarette cast to her side, she glanced down at the six exhumed bodies, tied together at the wrists with electric cable. "For me, this *is* the homage," she said without looking up, referring to the ritual devotion of the exhumation process itself, and not necessarily the identification of the individual bones to particular bodies. I followed Ana's gaze at the exposed bones before me; I could not even begin to understand what the bones and their exhumation must have meant to her and her family.

Luisa and Ana knew that they might never locate Martín's bones. At the most, they could only hope that the exhumation process itself—not the exhumation of his individual bones but of *someone's* bones—might purge Martín from his current place of violent death and obscurity, and purge them of the pain they felt that this was so.

Exhumation began with their desire to know where Martín was, and to retrieve his remains. Luisa and Ana hoped to recover some aspect of Martín—material or otherwise—for, as Luisa explained, "*Creo que todavia no me ha salido del cuerpo*. I believe it [the tragedy of my father's death] still has not left my body."

The desire to know and feel who her father was, via the exhumation, animated (and sometimes depressed) Luisa and her daughter during the exhumation process. The ethos motivating Spanish practices and rituals embodies what it means to be Spanish—and to have lost a family member, often more than one, during the war and the dictatorship.

Although the war and dictatorship were now in the past, and the Catholic Church no longer possessed the political power it had once enjoyed, Luisa was doubtful about the possibility of any formal form of reconciliation taking place in Spain in the near future. "*No se cae ni la puerta de la iglesia*—not even the door of the church falls," she told me. The institution of the Church cannot fall so quickly; the vestiges of its role in political oppression linger in the Spanish present.

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Militarizing Emergencies

With violent disruptions, or as a result of other unanticipated emergencies, including environmental disasters, states are often unable to provide basic services. Many countries also face chronic problems reflected in administrative incompetence, corruption, and failure of the rule of law. In the face of administrative ineptitude, the absence of judicial processes, or simply frail systems of government and broken infrastructure, external assistance may be inevitable in ways that bypass political partisanship. The Red Cross, established in 1863 and restructured in 1919 as the International Federation of Red Cross and Red Crescent Societies, has worked for over 150 years to provide emergency medical assistance and public health programs. Médecins Sans Frontières, discussed in Chapter 15, was established in 1971 at the time of the Biafran war in Nigeria, and in 2015, it was working worldwide to provide health and medical assistance to people impacted by epidemics, disasters, and civil disruption. Other independent organizations and multilateral agencies, private foundations and NGOs, operating with support from individual donors and donor countries, assist in providing essential food, medicine, water, sanitation, and emergency medical aid. There has been continuing debate about the approaches taken by some of these organizations, and the extent to which they bypass and so fail to address the politics behind the chronic incapacity of certain countries to meet the health and medical needs of their populations. Hence, the important point that Doug Henry and Susan Shepler have made of "chronically acute crises," alluding to the recurrent difficulties that many countries have to respond at times of crises, as rooted in problems of poverty, poor health infrastructure, and challenges in governance (2015: 20). War, we have noted, exacerbates poverty as its armies internationally destroy infrastructure and undermine governance.

The case studies in this chapter have emphasized the sorrow, suffering, and fear that saturate everyday life under conditions of conflict. Yet in the face of such tragedy, humans show remarkable resilience. Much of this resilience is at an individual level, whereby people work to make sense of seemingly impossible odds, but resilience also occurs at the community level. Even in societies where trust has been badly broken—in Rwanda, for instance, or in Palestine and Israel—people continue to build affective ties and sustain families, to support each other whether they stay or flee, and to take a public stand either on specific occasions—as in truth and reconciliation

commissions—or through their life's work. While many people, individually, are shattered by catastrophe, remarkably communities continue. One role for medical anthropologists is to further better understand how we, with health and other professionals, might repair the social fabric as well as individual bodies and minds.

Note

1. Some 17 million soldiers and citizens were killed during World War One. Over 20 million were killed just 50 years before in the Taiping Rebellion (1850–1854) in southern China (http://www.britannica.com/event/Taiping-Rebellion).

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