The Khmer Rouge executed her entire family. Their beatings left her unconscious, lying on the bodies of her loved ones. When my first Cambodian patient told me this story in graphic detail in 1981, my initial reaction was that it simply couldn’t be true. It seemed so unreal, like a scene taken straight from a horror movie. My instinct was to disbelieve.

My feeling was an example of what novelist Herman Wouk has called “the will not to believe.” Such a response is a common reaction to accounts of human cruelty and emotional suffering, and it is one of the reasons that political leaders, humanitarian aid workers and even psychiatrists have failed to appreciate the depth of war’s trauma. The model used to be a rubber band. War is hell, but we thought that once a conflict ended, those affected would snap back to normal. Physical injuries would linger, but the anxiety and fear that accompany any life-threatening event should disappear once the immediate danger passes. The general public had much the same attitude. In essence, the message from the outside world to war’s victims was: Be tough. Just get over it.

Indeed, that was the thinking about most traumatic events, from child abuse to rape. Now we know better. Awful experiences can cause damage that does not always heal naturally; the victims may need counseling, economic assistance and medication. Post-traumatic stress disorder (PTSD) was officially recognized in 1980, partly because of the experience of U.S. veterans of the Korean and Vietnam wars. But it has only been in the past two decades that researchers have documented the social and emotional consequences of war for civilian populations. These findings are revolutionizing the recovery of societies devastated by war.

In 1988 our team at Harvard University, with the support of the World Federation for Mental Health, sent a psychiatric team to Site 2, the largest Cambodian refugee camp on the Thai-Cambodian border. We interviewed 993 camp residents, who recounted a total of 15,000 distinct trauma events, such as kidnapping, imprisonment, torture and rape. Yet the international authorities charged with protecting and providing for the camp had made no provisions whatsoever for mental health services. Similar lapses affected other refugee operations the world over. Over time the reason became clear: the mental health effects of mass violence are invisible.

Put simply, it is easier to count dead bodies and lost limbs than shattered minds. Wounded people readily seek out doctors, but the stigma of mental illness is high, so traumatized people typically avoid psychiatrists at all costs. The lack of standardized criteria for mental health disorders and the differences among cultures have also contributed to the neglect. Local folk diagnoses may not match the disease categories of Western medicine.

The survivors of mass violence often keep their feelings to themselves because they fear misunderstanding—with good reason. In his memoirs, Primo Levi describes the fantasies he had while at Auschwitz. He dreamed of seeing his family again but also dreaded it: “It is an intense pleasure, physical,
inexpressible to be at home, among friendly people and to have so many things to recount; but I cannot help noticing that my listeners do not follow me. In fact, they are completely indifferent; they speak confidently of other things as if I were not there. My sister looks at me, gets up and goes away without a word—the grief is unbearable.”

People’s disbelief and disinterest are unfortunately quite real. They reflect the problem we all have in comprehending evil. How can human beings perpetrate such acts? Lacking a simple answer—and wishing to avoid our own intimations of guilt—we change the subject.

When international agencies finally began to address mental health, they first sought simple solutions. Yet providing mental health care is even less straightforward than rebuilding roads or treating malaria. Nevertheless, researchers have made headway; six basic discoveries point the way.

The first is the sheer prevalence of major psychiatric disorders among civilian survivors of war. Advances in psychiatric epidemiology—random samples of representative populations, utilization of lay interviewers and development of standardized criteria for diagnosis, even across cultures—have at last yielded reliable numbers. Our study of Cambodian refugees revealed levels of acute clinical depression and PTSD of 68 and 37 percent, respectively. Roughly similar numbers have been found among Bhutanese refugees living in Nepal and among Bosnian refugees living in Croatia. By comparison, in nontraumatized communities rates of 10 percent for depression and 8 percent for PTSD (over a lifetime) would be considered high.

Second, researchers have determined that the nature of the trauma can be rigorously measured. Psychiatrists used to worry that probing a patient’s traumatic experiences would be too emotionally disturbing. They also felt that patients would provide inaccurate accounts, at best exaggerated and at worst outright lies. But beginning in the early 1980s, a new movement emerged in medicine, associated with the activities of groups such as Amnesty International. Human-rights research-

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A modified checklist, the Harvard Trauma Questionnaire, focuses on trauma events and symptoms of PTSD. It now exists in more than 25 languages, tailored for each unique cultural context and tested empirically.

Using the Right Idiom

Third, medical anthropologists have codified non-Western conceptions of mental health disorders. In many societies, traditional healers and community elders, rather than medical doctors, are the principal source of health care, particularly mental health care. But some patients fall through the cracks: traditional healers are not able to heal their condition, and doctors do not recognize their vague somatic complaints as symptoms of an underlying mental illness. Extensive fieldwork in Cambodia, Uganda and Zimbabwe has now catalogued the wide range of folk diagnoses associated with emotional suffering. Our team has produced an encyclopedia of these diagnoses for Cambodia, so that Western-oriented practitioners can identify mental illness using local idioms.

Fourth, particular traumatic experiences are more likely than others to lead to depression and PTSD. Among Cambodian refugees at Site 2, the most harmful incidents involved blows to the head, other physical injury, incarceration, and watching the murder or starvation of a child. Lacking shelter and witnessing violence to other adults had less of an impact.

Fifth, some of the most potent events cause permanent organic changes in the brain. In the early 1960s, Norwegian researcher Leo Eitinger and his colleagues discovered a link between head injury and psychiatric symptoms in the survivors of Nazi concentration camps. According to more recent research, the beatings suffered by American POWs during World War II and the Korean and Vietnam wars often led to brain damage. Similarly, of 200 civilian torture survivors examined by Danish researcher Ole Rasmussen and his colleagues, 64 percent had neurological impairments. Even in the absence of direct physical injury, emotional distress can scar the brain. The few available studies of subjects with PTSD have revealed that certain structures in the brain, such as the hippocampus, shrink as a result of trauma. Some neuroscientists have begun to connect these early results to the persistent and debilitating symptoms of PTSD.

The sixth and final discovery demonstrates the connection between mental distress and social dysfunction. Last year my colleagues and I analyzed the serious disability associated with psychiatric distress among Bosnian refugees living in
From the end of the Thirty Years’ War in 1648 to the French Revolution in 1789, Europe’s princes fought one another with relatively small armies. France’s upheavals, however, gave birth to the concept of a “nation in arms.” Starting at the same time, the Industrial Revolution turned cities and factories into prime targets. In most wars of the past century, civilian deaths have outnumbered military deaths. Some countries have lost more than 10 percent of their population in a single war (for instance, the Soviet Union during World War II). Americans have been largely spared by geography.

Since World War II, Asia, Africa and the Middle East have become the world’s primary battlegrounds. In the conflicts that raged in Angola and Mozambique from the 1960s to the 1990s, more than 75 percent of the victims were civilians. A large number were also children: between 1985 and 1995, some two million children died from warfare, and another 10 million to 15 million were maimed physically or psychologically. One reason for the high civilian death rate is that many of the international conflicts since 1945 began as civil wars. The Korean, Vietnamese and Afghan wars, among others, started as internal conflicts but soon attracted outside intervention.

Amid the “new world disorder” of the 1990s, war often became a private enterprise. In the conflicts that followed the breakup of Yugoslavia, for example, much of the fighting was conducted by bands of irregulars who served out of personal loyalty, hope for booty or lust for revenge. Meanwhile U.S. armed forces began to do less fighting and more peacekeeping. The U.S. and its allies were able to minimize their own casualties in the war with Iraq in 1991 and in the Kosovo operation last year. Whether they can do so in future conflicts, however, is uncertain. Even von Clausewitz acknowledged the risk of “friction” during warfare—his euphemism for all the things that can go horribly wrong.

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![Diagram of civilian and military deaths](image)

**The Author**

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**Invisible Wounds**