transcultural psychiatry

December 2003

ARTICLE

'*Why are there so many drums playing until dawn*?' Exploring the Role of *Gamba* Spirits and Healers in the Post-War Recovery Period in Gorongosa, Central Mozambique

VICTOR IGREJA
Leiden University Medical Center

Abstract In the wake of a civil war, local resources can play a potential role in shaping the recovery process by providing both old and new exegeses for the disturbing effects of the past. Using the case of Gorongosa, this article aims to explore the ways in which the war has impacted upon traditional medicine by creating *Gamba* spirits that cause havoc but can also transform the psychosocial hurts of war survivors. Historically, traditional healing practice was under the sole responsibility of the *Dzoca*, an ancestral spirit that for generations was embodied in living people through lineage descent to exercise its healing powers. There is consensus among healers that the *Gamba* spirit and healers emerged after the war and are rapidly spreading throughout Gorongosa. I explore the emic theories to explain the *Gamba*'s puzzling origins and the role they are currently playing in Gorongosa.

Key words Central Mozambique • *Gamba* spirits and healers • post-war reactions • recovery strategies • traditional medicine

Publications on the multiple and prolonged effects of wars and natural disasters and the individual and community recovery strategies from non-western societies are scarce. Very little is known about the consequences of trauma exposure in the psycho-socio-cultural dimensions of survivors'

Vol 40(4): 459–487[1363–4615(200312)40:4;459–487;038904]

lives (De Vries, 1996; Richters, 1998; Suárez-Orozco & Robben, 2000; Summerfield, 1995). The absence of systematic knowledge is more evident concerning the nature and type of local resources mobilized to correct the effects of prolonged and multiple exposure to war traumas. An international literature review of epidemiological studies on the prevalence of war-related disorders indicates that of 135 studies, only 6% were carried out in developing countries (De Girolamo & McFarlane, 1996). There is still a lack of relevant information to help us understand the cultural patterns, social networks and recovery strategies developed by local cultures in the wake of war to reduce its lasting impact on civilian populations.

Most of the available cross-cultural studies on trauma and post-traumatic reactions have been confined to specific groups such as blacks, Indians, and Asian American Vietnam War veterans living in North America; refugees from South-East Asia and Eastern Europe living in asylum centers in developed countries (North America, Canada, Australia and Western Europe); and refugees from Africa living in camps near war-affected areas. For instance, there are quantitative studies on the prevalence of mental health problems among refugee populations from Rwanda and Burundi living in the crowded camps of Tanzania (de Jong, Scholte, Koeter, & Hart, 2000), in West Africa among Senegalese refugees living in camps in the Gambia (Tang & Fox, 2001), and a comparative measurement of four post-conflict and low income countries namely Algeria, Cambodia, Ethiopia, and Gaza (de Jong et al., 2001).

Harrell-Bond and Wilson (1990) carried out more qualitative observations and have documented the complaints of fleeing Mozambican survivors haunted by the spirits of their dead loved ones because they were not properly buried. Englund (1998) described the role of spirit exorcism and other non-discursive bodily practices in addressing the social wounds of war of Mozambican refugees in Malawi. These studies provide important insights into the ways in which local cultures interpret and provide responses to war traumas. However, it seems that local resources do not remain intact vis-à-vis their exposure to prolonged periods of violence or as a result of rapid socio-economic and political changes (Janes, 1995; Ngubane, 1977; Taylor, 1992). We still need studies aimed at understanding the structural and dynamic processes that take place within these systems in order to gain more insight into the ways in which war suffering is recognized, legitimized and provided with responses that help or impair the recovery of trauma survivors.

Most refugee studies are important for the information they provide regarding human rights violations, health problems and the needs of refugees. However, there are several confounding factors, which complicate the systematic understanding of the relationship of war exposure, the

fleeing process, the psychosocial consequences, and the activation of inner and outer coping resources in the host countries. Refugees almost everywhere live in a permanent state of fear because of the threat of being sent back to war-affected areas. The most common confounding factors are humiliation, acculturation, stigmatization, discrimination and unemployment experienced in the refugee camps or in the well-guarded asylum centers in western countries. The field of war trauma is in need of studies that address the long-term effects of exposure to extreme violence among the majority of populations who do not manage to flee and are forced to remain in the war zones living under extreme social conditions. There is still a need for long-term studies to be carried out when war survivors are settled in their places of origin, when communities are no longer living in a permanent state of fear and the sense of normality has been re-established. These and other post-violence conditions can allow us to acquire clearer insights into the consequences of war trauma and the main processes of recovery in non-western societies.

Medical anthropology has provided important insights vis-à-vis the crucial need to develop contextual and comprehensive approaches to understanding health, illness and healing practices (Csordas & Lewton, 1998; Feierman, 1985; Van der Geest & Rienks, 1998; Young, 1983). Research on trauma and extreme forms of psychosocial suffering has been gradually demonstrating that its impact encompasses biological, psychological, social, cultural, legal and political phenomena (Das, Kleinman, Lock, Ramphele, & Reynolds, 2001; De Vries, 1996; Eisenbruch, 1991; Kleinman, Das, & Lock, 1997; Marsella, Friedman, Gerrity, & Scurfield, 1996; Perera, 2001; Richters, 1998; Young, 1995).

The recognition of these intersecting and indivisible dimensions and their subsequent adoption leads inevitably to the formulation of questions related to the cultural variations in the aetiology, prevalence, expression, experience, diagnosis and treatment of traumatized populations (Marsella et al., 1996). As pointed out by Devereux (1956/1980, p. 9) '. . . at a cultural level, events or situations may produce trauma if the culture has no defense mechanisms available for relieving or buffering the shock.' Hitherto, western psychiatric thinking has paid very little attention to this important level of trauma understanding.

Within this analytical framework, the availability, accessibility and quality of local resources play a vital role in the recovery process because they provide a rationale of suffering that fits with the explanatory models of the traumatized individuals and families. Thus, the responses provided by traditional healers, social support and self-help groups, and religious leaders have been generally considered as a critical vehicle for trauma recovery (De Vries, 1996; Hiegel, 1994; Turner, McFarlane, & van der Kolk, 1996). However, what still requires exploration is a dynamic rather than a

static approach into the ways in which traditional healing practices are called upon to provide responses to the health needs of their populations as a result of exposure to new forms of extreme violence. We need to know how these traditional healing resources are shaped and re-shaped by violence and the ways they specifically adapt themselves to fulfill their function of helping populations affected by war. What kind of continuities or discontinuities does exposure to violence generate in traditional healing systems? To what extent may these continuities and changes help in the recovery process or impair better healthcare assistance for survivors? And, what kind of intervention do traditional healers apply to specifically address war-related psychosocial suffering?

The Gorongosa Context

Gorongosa is a former war zone founded on a patrilineal kinship, polygyny and an agricultural system of production. The family is the basic unity of society. It is a male-dominated society with strong emphasis on the principle that, after marriage (which is arranged by the payment of a bride price), a woman belongs to her husband. The man is the head of the household and takes the most important decisions concerning family and social issues. The historical and still prevalent cultural living patterns are based on the principle of dispersed patterns of residence. Families, most of them enlarged or extended, live far apart in their places of origin (known as *Madembe*). This type of social organization allows polygynous men to build the houses of their wives and young children in the same yard. It also allows them to freely open up fields of production in front of and around their houses instead of having to walk long distances to practice agriculture (i.e. separating the place of living from the place of production).

Violence in Gorongosa

Mozambique's recent history has been dominated by almost three decades of war intercalated by years of devastating floods and drought. The struggle for independence began in 1964 and ended in 1974 and the civil war continued from 1976 until 1992. The suffering was aggravated by droughts that affected the country in 1988–1989 and again in 1991–1992.

Although the war and droughts spread through the whole country, rural areas were the most affected. Different publications concerning the war in Mozambique suggest the existence of a variety of local dynamics of violence in different parts of the country (Chingono, 1996; Geffray, 1990; Hall & Young, 1997; Hanlon, 1991; Nordstrom, 1997; Schafer, 1999; Vines, 1991). In this context it seems necessary to examine the ways in which the war manifested itself differently from one region to another. Even within

the boundaries of Gorongosa District, a microanalysis of the dynamic of violence is required to understand how suffering was unequally experienced by men and women and by different individuals and communities.

Pain, hardship and misery affected the Gorongosa population for almost three decades and were accentuated by outbreaks of cholera, diarrhea and malaria in the absence of healthcare services, which had been destroyed by the war. During the entire period of civil strife, the majority of the people lived side by side with the soldiers from one side or the other. This former war zone became famous for the intensity of its conflict. The national military headquarters of the Renamo guerrilla army from 1981 to 1985 was based in this district and from the first signs of war in 1976, the district was divided between areas controlled by Renamo and by the government. Entire families and communities were divided between the two forces and were made to fight against each other. The lives of the population were governed by the particular regime under which they were living during the conflict. In Renamo-controlled areas the people were living in their own residences (*Madembes*), whereas in government areas the people were living in communal villages. However, the common denominator in the two organizational systems was that people continuously suffered traumatic experiences.

Within this context of multiple and prolonged disruptive experiences exacerbated by the absence of professional mental healthcare services, a research project was conceived in 1997, five years after the end of the war (in 1992). Its aim was to gather systematic and longitudinal data in a community-based setting on the following issues: (i) the ways in which Gorongosa war survivors perceive, interpret and address mental-health problems in the post-war period; (ii) the extent to which traditional forms of healthcare in Gorongosa play a role in helping war survivors recover from their traumatic experiences; (iii) to gain insights into the ways in which the appearance of *Gamba* as both a destructive spirit and healing resource is related to the prolonged years of exposure to violence and the role these factors are playing in post-war Gorongosa.

Methodology

Procedures and Participants

The present study is part of a larger ongoing project aimed at developing a comprehensive view of the nature and type of healing resources, and the availability, accessibility and quality of these resources in post-war Gorongosa. The project began in 1997 and has been carried out in full cooperation with the local authorities and two non-governmental

organizations: AMETRAMO (Mozambican Association of Traditional Practitioners) and AEPATO (Association Hope for Everyone).

After the initial bureaucratic procedures with the authorities from Gorongosa District, the following villages were selected: Vila Paiva, Kanda, Vunduzi (Cavalo, Nharoi, Massala) and two communal villages Casa Banana and Mucodza. In every location the main researcher and community activists from AEPATO conducted several meetings, first with the main gatekeepers (traditional authorities and chiefs) and then with the traditional healers to explain the objectives of the research and to obtain their consent. The participants agreed to cooperate and allowed us to observe and ask questions before, during and after treatment sessions.

Methodology

The main methods used were in-depth interviews and participant observation. Among other things, the interviews covered the following topics:

1. *Demographic data* (5 items): Age, gender, civil status, place of abode, and war circumstances.
2. *Characteristics of the profession* (6 items): the starting point of work as a healer; the teaching and learning processes including the time-frame of the duration of training; the family history of healing practice; the main instruments used during healing sessions; ceremonies and rituals surrounding the commencement of the profession; and differences between male and female healers.
3. *Illnesses, diagnosis and treatment according to age and gender of patients* (5 items): the most common illnesses being dealt with in the post-war period; the diagnostic process; the treatments applied; the place of treatment sessions; and the continuities and discontinuities registered within the healing practice as a result of exposure to war.

Ethnographic observations were made during diagnosis and in the different treatment stages in the healers' yard.

Results

Demographic Characteristics

The total number of *Naanga* or *Nhahana* (traditional healers) interviewed was 40. The nature of the healing practice is gender free, 60% were women (n = 24) and 40% were men (n = 16). Their ages ranged from 21 to 50, they were all married and were war survivors, i.e. they had spent the entire period of civil strife living inside the war zones in Gorongosa District. Besides healing activities, most of the healers, particularly the women, also practice agriculture to sustain their families.

The Local Exegeses of Health, Disease and Illness

Ancestor worship plays an important role in determining well-being and exegeses of illness and misfortune. Such types of beliefs seem to be widely practiced in Central and Southern African countries (Janzen, 1992). Yet it appears that in different cultures the relationship between the realms of the living and the dead is regulated by at least two principles: distance and proximity. In some cultures people respect their dead loved ones by maintaining close physical distance and contact. For instances, in the southern region of Mozambique people visit their dead loved ones almost every weekend. They go to cemeteries every weekend, and they are constantly cleaning their graves and offering prayers to the dead. In contrast, people in Gorongosa respect the dead by keeping a physical distance from them. People only go inside a cemetery to bury a relative and after the burial no one is allowed to cross the cemetery's invisible boundaries. In turn, the distance is regulated by the practice of ancestor worship. Centralized forms of such worship (such as those mediated by traditional healers) or decentralized ones (those carried out by individual families themselves within their households) make up part of the local system of beliefs, which can be observed in the majority of the communities in Gorongosa. It is believed that when this intricate web of relations is broken it unleashes a set of family conflicts that ends up with the manifestation of concrete physical and psychological symptoms among the living.

Nearly 10 years after the end of the war, it is believed that the 'disenchantment' of the dead vis-à-vis the behavior of the living is not confined to the appearance of concrete symptoms among the living. In this post-violence period, the powers of the dead are overwhelmingly puissant to the extent that entire communities sometimes wake up in the pre-dawn, frightened and shaking with fear because angry spirits have begun to shoot weapons. The shots are so real that everyone tries to escape with bags on their heads as if they were experiencing a military raid comparable to the innumerable raids registered during the long days and nights of the war. This phenomenon has already occurred twice (in 2001) in Casa Banana, one of the project's communal villages. Perera (2001) documented similar experiences in her work in Sri Lanka. In certain public places people began complaining of hearing voices brought about by intense supernatural activity and because of that they were refusing to enter and to work in these places (Perera, 2001).

These individual and communal post-war experiences suggest that to understand the local cultural dimension of war traumas it is necessary to determine first, the type of relationship that living people establish with their dead loved ones and see how the war disrupted these relationships, and second, the degree to which people believe that their well-being

depends on the performance of established ceremonies and rituals surrounding birth, marriage and death and the ways in which the years of social, political and economic crises prevented people from fulfilling these vital obligations (Igreja, Schreuder, & Kleijn, 1999). And third, an investigation is required of the capacity of the local socio-political, cultural, legal and medical structures to reorganize society in order to recreate their communities in a way that accommodates conflicting individual and family secrets and histories of persecution, abuse, humiliation and shame, marginalization (of the living and the dead) and extreme suffering. Needless to say, in such settings it appears that the mental health professional loaded with biomedical knowledge and armed with DSM-IV (American Psychiatric Association [APA], 1994) instructions may have very little influence. A *complémentarisme*, as referred to by Devereux (quoted by Nathan, 2001), can be achieved if we begin to accept that the DMS-IV is just one more representation of a world-view of mental diseases and illnesses among several others throughout the world. The *complémentarisme* suggests the possibility of different cultural representations of health, disease and illness working together to overcome their intrinsic inconsistencies and limitations. Methodologically it implies that these limitations can only be acquired, not through the logic of dominance of one medical tradition over the other, but through respect, in-depth studies and a critical approach of the different systems in order to produce knowledge regarding its potential to successfully restore health. In the case of Gorongosa medical tradition in this post-war war period, we still need in-depth and long-term understanding of its intrinsic dynamics and this study is in line with such *complementariste* methodology. The starting point is not to try to understand *Gamba* or *N'Fukua* in the light of post-traumatic stress disorder (PTSD). This article is an attempt to start understanding *Gamba, N'Fukua* and other conditions based on local categorizations, perceptions, rationalities, and explanatory models.

Characteristics of the Healing Profession

Of the healers, 55% were *Dzocas* (n = 22) and 45% were *Gambas* (n = 18). Among the *Gamba* healers 15 were women and only 3 were men. Despite the fact that healing is a gender-free profession, the gender difference among *Gamba* healers was clearly significant and two broader local exegeses are given below.

All the *Gamba* healers started working after the war whilst most of the *Dzoca* healers had started before the civil war and only a very few began during or after the war. According to the fundamental characteristics of the healing profession, *Dzoca* and *Gamba* are different types of healers. Historically, the healing system was the responsibility of healers using

Dzoca spirits, and healers using *Gamba* spirits only emerged after the civil war.

The DZOCA *Healers*

The most important characteristic of healers working with *Dzoca* spirits is that *Dzoca* is inherited through lineage descent. Historically and culturally, no one could become a healer if there had not been a history of traditional healing practice within the family. The healing heritage can come from both sides of the family, i.e. from the paternal or maternal side. The selection process of becoming a healer is often randomized and no one knows in advance if s/he will be chosen by the ancestral spirits to become a healer but everything begins with a disease (and it can be any type of disease). The person gets ill and based on the family's therapeutic choices they can take the sick person to a healer or to biomedical doctor. According to the results of the interventions, the family may change from one type of healing system to another.

If the patient does not recover over the course of time and the family sees that the disease has chronic features, the health-seeking behavior is immediately sharpened and confined to traditional healing. Further diagnosis follows until the healer discovers that the patient has a chronic disease that is being caused by the spirit of *Dzoca*. When *Dzoca* is revealed everyone knows that the patient was chosen to become a healer. The discovery of *Dzoca* can bring a resolution for the disease of the sick person if s/he agrees to continue the profession of the ancestors, i.e. to work as a healer. Janzen (1992) has termed the process of transforming the sufferer into a healer as the 'wounded healer,' which seems to be a widespread means of becoming a healer in Central and Southern Africa. Yet, it is also known that not everyone who suffers from a chronic condition becomes a healer (Reis, 2000). In Gorongosa, the basic foundation is that the sufferer must have a history of healing practice in his/her family in order for the transformation to take place.

Gamba *Healers and the Concealed Past*

Healers working with *Gamba* spirits follow the same basic rationale as that of the 'wounded healer.' However, *Gamba* healers differ considerably from the *Dzoca* ones because the former do not have a family history of traditional healing practices. They become healers by inheriting a history of violence and abuse within their families. This has represented a major historical change in the process of legitimizing the traditional healing institution in Gorongosa. Another feature of the *Gamba* as opposed to the *Dzoca* spirit is that the disease episode is accompanied by manifestations

of uncontrolled trance states. Based on the trance states, the possibilities for a multiple therapeutic choice are reduced. Family members and everyone in the community knows that traditional healers are the only ones who can address spirit-possession matters. This phenomenon follows one basic rationale. According to my informants, there is an historical and current belief in Gorongosa that if a person eats a tree called the *nbanda* and *murimbe* before being killed, his spirit sooner or later comes back to seek vengeful justice. Accordingly the power of these trees mixed with animals' blood allows the innocent deceased to return to the realms of the living to gain revenge. This type of spirit is known as *N'Fukua* and was also documented in the southern region of Mozambique (Honwana, 1998).

The elders in Gorongosa who survived the last civil war claimed that *N'Fukua* probably emerged in the late nineteenth century as a result of the massive migration movements of southern populations aimed at dominating the people of the central region. This result is consistent with previous descriptions by Junod (1927/1996, 1934). These tribal confrontations resulted in resistance movements that were mystically embodied through the *N'Fukua* spirit. To resist even after death, the bodies of the warriors from the central region were preventatively treated with roots of wild trees and animals that would allow them, in the case of an innocent murder, to become a *N'Fukua* spirit, i.e. the spirit of a dead person who has the power to wake up and return to the realm of the living to seek revenge. Apparently *N'Fukua* would serve to intimidate foreign aggressors and to pass on the message that the death of a warrior from the central region would cost a lot and affect the aggressors for generations to come.

Within this context of rapid but violent transition in the central region in the last 100 years it was not viable to fully develop and transform the *N'Fukua* spirit to such an extent that it could generate a category of healing synergies for the benefit of individuals and communities in Gorongosa. Historically, *N'Fukua* remained a malevolent spirit and society was never able to generate healers working with *N'Fukua* spirits to control its pervasive effects. For this reason, as my informants asserted, 'in the past *N'Fukua* was always a very secret phenomenon. Its not like *Gamba* that you can hear the drums playing almost everyday.' Yet when the last civil war started in the central region of Mozambique, people were culturally and historically aware of the possibilities of manipulating the world of the spirits to defy the enemy. And there are several accounts portraying the ways in which Renamo and government soldiers searched for preventative traditional treatments to protect themselves against enemy bullets (Wilson, 1992) and to become *N'Fukua* in case of murder. This is one of the reasons why, after the war in Mozambique ended, many soldiers sought the help of healers to prevent the aggrieved spirits of innocent people they had killed during the war from coming back to seek a revengeful justice

(Dolan & Schafer, 1997). A similar cultural process aimed at helping perpetrators and victims of violence has been documented in Zimbabwe (Reynolds, 1990).

The healing prospects that were not achieved with *N'Fukua* emerged with the advent of the *Gamba* spirit, a new type of unforgiving spirit with features similar to *N'Fukua*. The *Gamba* spirit was set in motion to overcome the weaknesses of the *N'Fukua* spirits in its healing component. *Gamba* has the potential healing side that *N'Fukua* clearly lacks. When the diagnosis of *Gamba* is confirmed, it is metaphorically said that the ancestors of the *Gamba* sufferer 'ate a person' in the past. This is an interesting example of a powerful metaphor, which can function as 'reminders of a story that is already authoritative (even if it remains implicit or untold)' (Kirmayer, 2000, p. 155). The revenge of the innocent victim in the form of *N'Fukua* and *Gamba* is not necessarily directed against the person who committed the crime. *N'Fukua* and *Gamba* can take revenge against any of the murderer's relatives. In this respect *N'Fukua* and *Gamba* can have transgenerational effects.

As described above, *N'Fukua* and *Gamba* are the spirits of assassinated individuals (very often men), yet there are important differences between the two in terms of effect, the possibility of interventions, historical records and gender. *N'Fukua* is known to be a very old spirit that existed long before the colonial and civil war, although in the past, it was a secret phenomenon. *Gamba* is a new type of spirit that emerged soon after the last civil war and there was a general consensus among the traditional healers interviewed that it is indeed a recent phenomenon that appeared after the 16 years of civil war. This result is consistent with observations made by Marlin (2001) among survivors of the war in Tete Province in the central–northern region of Mozambique. In fact, Marlin's informants systematically insisted that the region of Gorongosa District and the events that took place there during the years of prolonged war were responsible for the aetiology of *Gamba* spirits (Marlin, 2001). It is not clear whether Marlin's informants referred to Gorongosa, as the progenitor of the *Gamba* spirits in a pejorative way but what is also interesting is the fact that Gorongosa people are not sure about the *Gamba*'s origins. They all agree that it emerged after the last civil war but no one is clear from where. There are several views and one suggests that after the Nhazonia massacre perpetrated by Ian Smith's troops in 1976 against Zimbabwean refugees settled in the Nhazonia refugee camps (in Manica Province), traditional healers used the victims' bones to make medicines and introduced the *Gamba* spirits to central Mozambique. This also explains why these spirits speak in Shi-Shona or Shi-Ndau. Whatever the multiplicity of historical narratives regarding *Gamba*'s origin, the commonality in these narratives is the extreme violence it evokes.

An important singularity of the *Gamba* spirit vis-à-vis *N'Fukua* is that there is the possibility to transform episodes of suffering into potential sources of healing. For that, the *Gamba* spirit demands the body of the afflicted person to work as a healer otherwise the suffering can never be terminated and everyone in the family is condemned to suffer the consequences. When an agreement is reached between the family of the afflicted person and the *Gamba* spirit, the disease is transformed into a potential source of healing. After the interventions, the afflicted person begins to work as a *Gamba* healer. With the *N'Fukua* spirit there is no possibility of transforming the suffering into a healing process. A person possessed with the *N'Fukua* spirit has to live with the burden of it forever. Culturally, these women are considered to have two husbands, one living and one dead, and the living has to respect the wife and the dead husband.

An intriguing fact is that very often the *Gamba* spirit does not express itself in the local language of Gorongosa but in Shi-Shona or Shi-Ndau. In a conscious state, the holder of a *Gamba* spirit is unable to speak these languages. During a trance state, the spirit speaks a language unknown by its host (locally called *Tchiquiro*). Nowadays both *N'Fukua* and *Gamba* are well-known expressions of transgenerational family conflicts that result in extreme physical and psychological suffering among living people.

Gamba *and Gender Asymmetries*

A persistent question concerns gender asymmetries. As seen above, 15 of 18 *Gamba* healers are women and the question is why. A simple and straightforward answer is that this is because young women are the main targets of *Gamba* spirits' incursions. But such an answer does not advance anything new. A more elaborate answer requires an analytic approach that traces the history and dynamics of violence during the last civil war and the ways in which civilians – particularly women – suddenly became targets of the soldiers' weapons and desires.

At the outset of the war, the majority of the Gorongosa people were aware of the possibilities of manipulating the world of the dead to insure victories over their enemies. This was part of an old and well-known tradition and there was nothing new in it. The only thing which civilian people were not aware of was the fact that the violence was going to reach such a cruel and dehumanizing level, to the extent that they themselves would have to engage in spiritual manipulations to get some kind of protection that could not be obtained by any other means. That is why women came to play a pivotal role as targets of the dreaded spirits but also have the gender that embodies the seeds of healing in the post-war period.

Two local exegeses can be extracted from my long-term work among the Gorongosas to explain the role of gender in the *Gamba* phenomenon. First,

as described above, in order for someone to 'wake up' from death to pursue revenge, the person had to be treated while s/he was still alive. And the majority of people that were treated with traditional remedies before their alleged innocent death were young and single men. For this reason when they wake up and return to the realm of the living to seek revenge they ask for compensation in the form of the body a young woman. When occasionally the *Gamba* spirits possess the body of a young man it is said that this is because there are no women in his family to host the spirit. There are also cases of young men, driven by the ambition of becoming healers, who apparently buy a *Gamba* spirit to work with as a healer. But these are exceptional cases and it is difficult to find informants with such personal experiences. Even in my privileged position due to the close contact I have with healers from several locations in the district, the healers I was shown who have bought a spirit refused to share their experiences with me. It is also interesting that when it is a woman that was treated before her innocent murder, the privilege of revenge mysteriously does not remain symmetric to the men. It is said that her spirit can only reach the realm of the living to seek revenge when her husband dies too. Then the spirit of the husband comes back to get revenge for his wife's innocent murder. And again this logic of power relations contributes to determining the prevalence of *Gamba* spirits among young women rather than men.

The second explanation and the one that still remains very secret is based on the atrocities that young women were persistently subjected to during the war in Gorongosa. Soldiers from all sides in the conflict exposed young girls to abuse, sexual assault and rape. The abuses against young and adult women were more extreme through the practice of *Gandira*, which was a Renamo's military strategy to support their war efforts. *Gandira* was physically devastating because of the forced labor attached to it but also because it represented a radical discontinuity in the role and place of women in society. In the name of *Gandira* women were forced to produce food to feed the soldiers; when the food was ready they had to carry it on their heads covered by the dark of the night to far and unknown places; they were separated from their families for days, weeks or months; during these forced household absences they were heavily exposed to rape; and it very often happened that after doing *Gandira*, women did not know the way back to their houses because the transportation occurred in the middle of the night; they were geographically disoriented and abandoned. *Gandira* was a permanent dehumanizing and violent experience that showed that women did not have control of their own bodies or of their will.

Within this context several parents searched for traditional treatments provided by healers to protect their young daughters from the extreme

burden of *Gandira* and consequent sexual violence. To fulfill this vital need for protection, traditional healers secretly prepared a medicine that consisted of a mixture of roots of wild trees and flesh and bones extracted from the corpses of dead soldiers that could easily be found within the war zones. The rationale was that to defy the enemy one has to use parts of his body to make protective medicines. The way in which the ritual was applied to protect young girls remains highly secret but with the passage of time and long-term systematic observations I have been accumulating evidence indicating the presence of violence during its implementation. With peace, the spirits of these soldiers whose bodies were used to make protective medicines are coming back to revenge and request reparation, and they install themselves in a young women's body. For this reason there are more young women than men suffering with *Gamba* spirits. By contrast, the process of preparing and performing the ritual was loaded with violence toward the subject of protection (young girls), and for reasons of shame and feelings of guilt among the parents that were actively involved, no one is prepared to disclose the truth behind these experiences. Clearly, *Gamba* spirit-possession follows the rationale of the wounded healer (Janzen, 1992) – but in this case, hurts provoked by traumatic war experiences – using the body of the most wounded (women) to provide the vehicle that allows shameful, amoral and traumatic experiences to be expressed, acted out and dealt with in the community setting and witnessed and acknowledged by everyone.

The Learning Process, Duration of Training and Diagnostic Instruments

Neither *Dzoca* nor *Gamba* healers have any specific type of training, nor do they have a rigid timeframe for the duration of training. One month was the minimum timeframe mentioned by most of the healers, and this can be followed by sessions for consultation training that may last up to a year. The healers are specialized and treat only one type of spirit, i.e. a *Dzoca* healer cannot provide training to someone diagnosed with a *Gamba* spirit and vice versa. All the healers agree that *Gamba* spirits are powerful and dangerous and that only a *Gamba* healer can deal with people suffering from *Gamba* spirits. And because of the increasing prevalence of people, in particular women, suffering with *Gamba* spirits, the *Gamba* healers are much in demand in Gorongosa in this post-war period.

An important marked difference between *Gamba* and *Dzoca* can be observed in their diagnostic instruments. The *Dzoca* healer uses an instrument called a *Mutchira*, which is prepared with the tail of an animal. The *Gamba* healers use a locally designed instrument called *Ntchorora*, which is a huge knife similar to a bayonet. During the therapeutic process the

healers do not use the bayonet in any way to inflict violence upon their clients. The bayonet is said to symbolize the violence and brutality involved in the assassination of the innocent victim. Most of the *Gamba* healers use red clothes, which again symbolize the inherited history of violence and pain inside the family of the healer. The bayonet and the red clothes function as identification mechanisms between the *Gamba* sufferer and the healer. When the patient is in a trance state, the bayonet of the *Gamba* healer serves to irradiate signs of empathy and to acknowledge the suffering the patient has gone through. The bayonet establishes a horizontal relation that facilitates the communication and the mediation process between the *Gamba* spirit and the relatives of the host of the spirit. The same process is applied if the healer has to carry the spirit of the patient. She uses her bayonet to perform this type of diagnosis.

Ceremonies and Rituals Surrounding the Start of the Practice

All the healers stated that after the learning period a ceremony takes place in the house of the healer–beginner to inform the spirits that s/he is ready to start a healing practice. This ceremony also serves to inform the neighbors and others that another healing resource is available in the community. Besides the transmission of healing techniques, the healer–teacher buries medicines in the vicinity of the house of the new healer both to protect the healer against evil spirits and to attract patients. Following the public ceremony the healer–beginner has to have sexual intercourse with his/her partner on the same night. However, there was no agreement about this ritual among healers – or sometimes they felt ashamed and simply laughed when asked about it. No gender differences were reported among the healers but some inconsistencies appeared concerning honesty. A minority of female healers stated that male healers were less honest with their patients than female healers were.

The Setting, Diagnostic Process and Types of Interventions

Healers very often perform their initial work in the yard of their own house or in the patient's house. They can also work inside a hut. In special cases they apply interventions by a riverside, in the middle of a forest, and at crossroads between villages. According to the type and nature of the problem, the work of healing essentially involves the patient and his/her relatives, with healers attending their patients during the day or at night (and staying until dawn).

During the diagnosis healers must make use of all their spiritual powers because society expects the patient not to utter a word about his/her problem. It is up to the healer to understand and provide results. *Dzoca*

and *Gamba* healers use several types of techniques to perform the diagnosis and to set up intervention strategies. These include bone-throwing, soul reading by using a coin filled with the spit of the patient, sniffing with the *Mutchira* (*Dzoca*) or bayonet (*Gamba*), dreams, trance states, and simple observations of the patient. All the healers asserted that they sometimes make a diagnosis and offer treatment based on information supplied by healing spirits during dreams. For cases related to spirits, the diagnosis and intervention are made through a trance. First, the healers try to put the patient into a trance and if they fail, the healer him/herself has to go into a trance.

All the healers have a formal personal assistant called an *Nhamaricumbe*, which is a gender-free profession. The *Nhamaricumbe* plays an important role during the diagnosis phase by working as a mediator between the healer and the patient and his/her family. Sometimes the *Nhamaricumbe* is also responsible for collecting medicines in the bush. The diagnosis and treatment involve a great deal of body movement because in order to activate the trance state the healers use the sounds of drums, songs, the clapping of hands and dancing. In fact, people in the community work as informal assistants. Community members on a voluntary basis take part in the healing sessions to help in the performance and without their help it would be difficult for healers and their assistants to succeed in inducing trance states among their patients. In post-war Gorongosa most of the drums that one can hear playing until dawn are being played in the yards of *Gamba* healers and their songs have a specific rhythm and message.

In general, healers apply different kinds of treatments ranging from the use of herbal medicines, the blood of animals and the use of spiritual powers provided by *Dzoca* or *Gamba*. Sometimes a healer can have more than one *Dzoca* or *Gamba* spirit. In such circumstances a healer is considered to be even more effective than usual. The idea is that the multiplicity of spirits allows the healer to extend the range of diagnosis of different types of health problems and subsequent courses of treatment. It is also believed that these healers have strong defense mechanisms against witchcraft because some of their spirits are solely devoted to protection.

Health Problems Observed by the Healers: Age and Gender Differences

Amongst the healers interviewed there is no rigid division regarding the type of problems they saw. All of them deal with children's and adult problems. Gender divisions play a significant role in the broader context of local politics and regulating society but do not exert the same influence in healing practices. Male and female healers address the diseases and suffering of both sexes. Minor differences can be found, i.e. ethically a male

healer cannot treat women suffering from sexually transmitted diseases unless the male healer has a female *Nhamaricumbe*. But female healers reported that they treat men with sexually transmitted diseases regardless of whether they have a male *Nhamaricumbe* or not. The same ethical issue is involved in the management of pregnancy and childbirth, which has a female monopoly. But in general, the power of healing is a function not of gender but of the healing spirits, i.e. there are very popular men as well as women healers in Gorongosa.

All the healers reported that the most common health problems could be divided into three age groups: children, adolescents and adults. Children often suffer from a condition termed locally as *Madzawde*, *Phiringaniço* or *Ku Kanhica*, which is thought to result from the breaking of traditional birth rituals by the parents of young children (Igreja, 2003). These three health conditions could be compared with symptoms of protein energy malnutrition (PEM) (Barltrop & Sandhu, 1985).

Among adolescents, particularly girls, all the healers reported that the most common health problems are related to spirits of *Gamba*. Because of the importance of this condition and the pain and suffering it is causing in post-war Gorongosa, a detailed description is given below. There are also cases of adults suffering with *Gamba* spirits, but they frequently suffer from chronic headaches, nightmares with symbolic or war-related contents, body pain, malaria, diarrhea, sexually transmitted diseases and infertility.

It should, however, be stressed that people seldom consult a healer because of war-related dreams unless the dynamic of the dream is similar to *Mawewe* or on the days following the dream the person develops physical symptoms. In the local classification and categorization of nightmares, *Mawewe* is defined as a frightening dream in which the dreamer cannot wake up by him/herself. Consequently, the dreamer moves his/her body and legs and screams continuously in search of help. When people nearby hear the screams they quickly wake the person up by shaking him/her and saying 'wake up, wake up, what is happening to you?' The person wakes up shaking with fear and replies, 'I was about to die, I was about to die, the soldiers wanted to kill me, and they wanted to kill me.'

Mawewe is so frightening that in some cases the person dreaming can barely open their eyes after being shaken. S/he slowly blinks but cannot communicate verbally with other people for several minutes. Body weakness, sweating and palpitations often accompany *Mawewe*. This kind of bad dream upsets not only the individual dreamer but also the whole family. For this reason, the dreamer, with his family, immediately consults a healer to try to correct the ill effects of *Mawewe*. The healers have a full apparatus of herbs and symbolic interventions to deal with these physical

and mental health problems. And these interventions do not require the trance-state phenomenon either from the healer or the patient.

Particularities of GAMBA *and Trance Episodes*

The rule of *Gamba* is that often its appearance starts some months after the targeted young girls get married. Exceptions to this rule can also be observed with very young virgins of 10–12 years of age who sometimes also show symptoms of *Gamba*, mainly trance states. At the beginning they have uncontrolled states of trance and only with the passage of time do the women learn to control these reactions. Sometimes the distress caused by a girl's husband can trigger a trance episode beyond her own control. They also suffer with a constellation of symptoms including stomach pain, overwhelming experiences of infertility, miscarriage and child mortality, serious marital problems, and the disintegration of family ties, social stigmatization and isolation.

The most common and well-known form of psychological symptom found among young women is chronic nightmares loaded with sexual violence caused by *Gamba* spirits. Zur (1998), while working within the Mayan society, observed a similar phenomenon among war widows. Women believe that a spirit of a dead person designated *aj tol* enters the house and rapes women without them knowing it (Zur, 1998, p. 258). However, traditional healers in Gorongosa stated that the women suffer not only because of sleep disorders and distressing nightmares but also because very often they are experiencing infertility problems. The emic exegeses establish a correlation that involves nightmares with sexual assault, which in turn decreases a woman's interest in having sexual intercourse, and leads to infertility problems.

Diagnosis of GAMBA

During the diagnostic session the trance episode follows a specific pattern. First, there are some ritual preparations carried out by the healer and his/her *Nhamaricumbe*. They clean the yard of the healer's house, put a mat on the floor and purify it with a mixture of herbs supposed to attract the *Gamba* spirit to provide a diagnosis. The diagnosis implies that the spirit has to speak through the body of the patient to reveal its origin and the reasons why he is making the patient and her family suffer. The patient sits down in the middle of the mat and they rub the same type of mixed herbs on her body. Second, the healers and their assistants together with the patients' relatives and neighbors begin playing drums to a specific rhythm, clapping their hands, and singing songs with special messages to induce a trance state in the patient. Janzen (1992) has observed

and reported similar experiences regarding the use of music in healing sessions.

Through the sound of the drums and the movements happening all around, the patient begins sobbing, shaking her body and wailing. I have observed that when she reaches the climax, she gives a loud involuntary scream, falls down, yawns as if waking up from sleep, and then stands up with a new name and identity. The music stops and everyone keeps quiet. The trance state represents the embodiment of the identity of the assassinated person. Physiological changes can be observed: the woman has a lot of physical strength and she wheezes and gets a different and stronger male voice. She speaks a different language that in a conscious state she does not know how to speak, she makes uncontrolled eye movements, she is violent and exhibits restless behavior. She can run, jump and fall without apparently feeling any pain.

The embodied spirit speaks with temerity and assumes a judgmental position threatening havoc on every relative's household. The *Gamba* spirit also threatens to afflict deadly diseases and misfortune on everyone including the healer if they do not take him/her seriously. Through the body of the girl the spirit asks for recognition of the fact that the relatives (ancestors) of the young girl killed him. The discourse of the spirit is awash with expressions of hatred and claims of revenge, justice and reparation. With the mediation of the *Gamba* healer, the revengeful spirit proffers questions that the relatives have to answer.

During the dialogue with the *Gamba* spirit the relatives are often afraid and the *Gamba* healer and assistants have to prevent the young girl from hitting her relatives. The relatives hear for the 'first time' about the history of violence, abuse and humiliation that exists within their family. When the session has finished, the patient gives a loud scream again and falls down. Then she wakes up and recovers her known identity but feels tremendously weary. She has no memory of the events that took place while she was in a trance. Only the bystanders can tell her what happened.

Intervention Strategies for GAMBA *and* N'FUKUA *Spirits*

To deal with *Gamba* and *N'Fukua*, the patient's whole family has to participate in the healing sessions. An important aspect of the treatment is that it is not the healer who determines the type of intervention that should be applied. It is the *Gamba* or the *N'Fukua* spirit who decides how justice and reparation can be achieved in order to restore the health of the patient and her family. Very often the content of the reparative justice as requested by the *Gamba* spirits involves more or less the same topics: young virgins, sex (penis and testicles), local drugs, alcohol, tobacco, red clothes, and symbols of violence (knives, pistols, military boots and uniforms). Every case

requires a different form of intervention. The *Gamba* healer works as a mediator and witnesses the revelations made during the diagnosis. The healer can only influence the course of the diagnosis by continuously requesting that the *Gamba* and *N'Fukua* spirits moderate the outbursts of anger and establish a dialogue with the patient's family.

Although the recent appearance of *Gamba* spirits is related to the prolonged years of violence that took place in Gorongosa, *Gamba* healers are not trying to establish a direct link between the *Gamba* phenomenon and the persistent abuses, persecution and killings that happened during the civil war. We have observed that during the trance states the assassinated person embodied in the patient's body often refers to experiences of violence that occurred '*kale, kale*,' meaning a long time ago, before the civil war. The timeframe of the traumatic events is not specified and apparently is not relevant to the course of diagnosis and treatment. Yet in some cases the spirits clearly specify that they were killed during the last civil war.

The most important aspect of the *Gamba* healers' work is that they try to recover fragmented and traumatic images and feelings associated with violence and the killing of innocent people. For that, the patient's family has to make real contact with the dead. Only the spirit of the dead embodied in the patient's body can reveal the origins of the disease afflicting the patient. Even if the patient and his/her relatives 'never knew' about the existence of a violent history inside the family prior to the day of the revelation, the real images of the dead are retrieved from the inner world of the patient and projected to the outer world. Following the trance episode, the patient recovers her known identity. But because of amnesia the patient is not able to recollect what happened during the session. The healer and the relatives of the patient narrate the events that took place during the trance episode so that the patient can become familiar with the parts of her unknown self. This is congruent with the prevalent idea in Gorongosa culture that everyone simultaneously has a living and a dead body. The totality and interaction of both makes the self. Culturally, the self is constructed and shaped by the image that the group projects to the individual. In turn through the trance states the individual projects the hidden parts of his/her self to the group; and again the group re-project the re-elaborated images to the individual. For in instances when I asked how an individual saw himself, the answer was always that 'only the others can say something about me.' And spirit possession is the raw form of 'knowing oneself through the others,' including the fragmented parts of the self.

Such experiences suggest that the *Gamba* phenomenon was created to timely and harmoniously accommodate contradictory experiences that intrinsically involve complex questions related to violence and physical

and psychological abuse, health and disease, morality, justice and reparation. It is clear that the war and its vicissitudes affected everyone – entire families were compulsorily divided, forced to hate one another and to fight and kill each other. The crux of the matter is that with peace and the need to live in a new society based on constructive rather than destructive relationships these intriguing past experiences need to be accommodated and reconciled without inciting more violence. It is in this context of harmonizing contradictory and apparently irreconcilable experiences that the potentialities of the *Gamba* spirits and their healing synergies appear to thrive. As described above, the diagnosis process of *Gamba* allows the free expression and re-enactment of concealed experiences of violence and abuse. Both victims and perpetrators of such abuses come together to face the past under the strict mediation of the *Gamba* healer and the attentive observations of other community members. In the confines of such sessions, the *tchiquiro* (spirit host) and her families are allowed to establish a rupture with the daily forms of dialogue, confrontation and mutual respect. Everything that is hidden and hurting inside the hearts has forcibly to come out to be worked through and there is no control of the type and level of language and vocabulary used.

The overall goal of the session is to achieve justice and in fact the session ends with an acknowledgment of the abuses and traumatic experiences that took place in the past and the family members repair the havoc (*ku lipiwa*). This is a positive strategy that differs significantly, for instance, from the strategies of conflict resolution applied by the Bunyole from eastern Uganda (Whyte, 1997). Whyte (1997, p. 197) observed that the Bunyole make an effort to keep their interpersonal conflicts and tensions hidden from others so that they can go ahead with 'civility on the surface and hatred in the heart.' The spirits of *Gamba* represent a breakthrough for this type of strategy in the sense that people have to do *ku bueca* (to confess or to talk about something that is concealed) about what happened and what is going on inside their hearts (*shungo* – hatred). Within this context of *Gamba* spirits there is an open avenue to help face traumatic memories and no need for grudges or physical revenge, which in several parts of the world still perpetuate the cycle of violence within families and in society in general.

Yet most of the healers in this study, including those with good reputations, were unanimous in declaring that disorders caused by *Gamba* and *N'Fukua* are difficult and dangerous to treat. This is especially the case when healers try to perform 'spiritual surgery,' i.e. to completely remove *Gamba* and *N'Fukua* from the body of the patient. This is a life-threatening intervention and for this reason is the most expensive treatment available. There are many traditional healers who prefer to contradict the principle of their raison d'être by refusing to be involved in spiritual

surgery because of several past and recent reports of healers who died while trying to treat patients suffering from *Gamba* and *N'Fukua*. None of the healers in this study dared to talk about *Gamba* and *N'Fukua* with the same confidence as other diseases and spirits. With the *Gamba* spirit there is a possibility of not curing but of transforming the condition. In other words, although after the intervention the sufferer in general enjoys good health, the diseases that once affected her do not totally disappear but are replaced by healing powers, i.e. if a person breaks the agreement with the *Gamba* spirit the disease automatically returns and this time in a more dangerous form. There must be a serious compromise from the *Gamba* healer about using her spiritual powers to help other *Gamba* suffers, and her behavior must be in accordance with the expectations that society has vis-à-vis those who dominate the art of healing. With the *N'Fukua* spirit the patient has to learn to endure and control these experiences or the healers hive off the spirit onto a young girl in the family. The problem is then hushed up and transferred to another generation.

Discussion

Social scientists have insisted upon the need to collect data on traditional medicine because of the fear that this knowledge will rapidly disappear (Ellenberger, 1970). This is particularly true in cases of prolonged exposure to war and this study has tried to demonstrate the ways in which the civil war has impacted on traditional forms of care among the Gorongosa people in central Mozambique. The brutality of violence not only caused disturbances at the individual level, but also disrupted family and community ways of living (Igreja et al., 1999; Schreuder, Igreja, Van Dijk, & Kleijn, 2001). After the war in Mozambique, the survivors, as in many other war-affected countries, were seen by the state as unimportant, isolated peoples living in remote areas (Cohen, 2001).

Yet the most interesting fact is that war survivors in Gorongosa have tried by themselves to acknowledge and recognize the pervasive effects of violence on the individual and society. Recognition and empathic identification with survivors were made through the timely creation of the *Gamba* spirits, which are an expression of extreme suffering and equally a potential source of healing. The case of the *Gambas* in Gorongosa suggests that as a result of exposure to extreme violence, local cultures may not resign from the 'work of survival' (Nordstrom, 1998) and recovery. It seems that local communities do not remain apathetic, merely waiting for the alien trauma experts to arrive and to teach them about the pervasive, but also sometimes inexplicable and contradictory effects of violence. Rather they look to their leaders – in this case traditional healers – to try to provide responses to individual and communal suffering.

These local forms of legitimization of suffering due to exposure to stress and trauma were also observed among the Digo people on the East African coast (De Vries, 1996). Although De Vries does not provide a comprehensive view, and neither does he give the name of the new label attributed to the condition, it appears from the study that the Digo people expanded their traditional medical system as a result of their exposure to stress and trauma (De Vries, 1996).

Another example of local ways of making sense of traumatic experiences was observed among the survivors of the 1994 genocide in Rwanda (Bolton, 2001). Although Bolton is skeptical about the creative capacity of the Rwandan survivors, the key informants in this study stated that *Guhahamuka* was a new concept that emerged after the genocide and is being used to express the mental and emotional effects of the genocide (Bolton, 2001). The study does not provide insights into the ways in which traditional healers explain the *Guhahamuka* and try to address it, but these are relevant and unequivocal examples that show that PTSD is as much the result of local socio-cultural, historical, military and political invention (Young, 1995), as are *N'Fukua*, *Gamba*, *Guhahamuka* (Bolton, 2001) and several other expressions applied to acknowledge extreme forms of suffering around the world.

The case of *Gamba* suggests that in the post-war period health and justice at the individual, family and community level cannot be viewed as two separate entities. A relevant observation in this regard is made by Kleinman et al. (1997) that the category of social suffering encompasses conditions that simultaneously involve health, welfare, legal, moral and religious issues.

The restoration of health among *Gamba* patients is achieved through a permanent endeavor to find acknowledgment, justice and reparation. However, because of the complexities of the circumstances in which families and communities were divided and forced to fight against each other during the war, the process of achieving justice and reconciliation has to follow a specific course.

During the diagnosis of *Gamba* spirits, the *Gamba* healers and the people present in the session engage and argue for several hours, yet they are not eager to make a detailed inquiry into the circumstances of the abuses and killings. The innovative aspect here is that *Gamba* seeks a type of restorative justice that avoids blackening and humiliating the offenders. Under the gaze of the healer and his/her assistants, the victim is allowed to exhort her relatives fearlessly in order to pave the way for recognition and reparation. In this way the health problems and any related social consequences are confined to and dealt with within the boundaries of the healing session and of the local community.

The field of international mental health assistance dominated by the western discourse on health and disease is in need of a more prudent

approach to provide a decent life for survivors of different forms of violence in non-western societies. But instead of rushing to teach survivors the meaning of alien concepts such as trauma, post-traumatic stress disorders and psychotherapy, it might be sensible to give local communities in the post-disaster period the time 'to meet with themselves'. An intrusive interference in this critical process that individuals and communities have to go through following periods of extreme stressful conditions may debar the process of cultural production and re-invention of communities and ways of life. The Gorongosa case suggests that local communities need time to settle and reorganize their socio-cultural, political and economic structures that could lead to a new type of individual and community relationship. It might then be possible to acquire a clearer understanding of the nature and type of problems that require outside input in combination with local resources to provide mental health services for survivors in greatest need.

Continuities and Discontinuities in the Healing Process

The recent history of traditional health care in Gorongosa cannot be separated from the total history of violence in Mozambique including colonial domination and the Marxist–Leninist post-colonial policies that tried in vain to eradicate ancestral ways of life. The appearance of *Gamba* clearly represents an expansion of traditional medicine in Gorongosa and because of the high prevalence of young women suffering with *Gamba* spirits; *Gamba* healers are becoming more popular than *Dzoca* healers. Competition between *Gamba* and *Dzoca* healers may generate struggles for power and control over local politics in terms of the definition of the most important symbols representing the traditional medical field in general, and health, disease, and intervention strategies in particular.

So far, *Gamba* healers only have informal recognition from AMETRAMO, the main corporation representing traditional practitioners. Another source of conflict may be generated by the fact that *Gamba* healers are significantly younger than their *Dzoca* colleagues. Their youth allows them to make more elaborate performances during diagnosis and intervention strategies, something that attracts people and thus increases their 'market of patients' to the detriment to their *Dzoca* colleagues. This rivalry, although still in a latent form, is shown in the following observation: as part of a project, AMETRAMO and AEPATO organized a gathering of healers living in different villages. Both types of healers marked their presence and before the knowledge and experience exchange began, there was a performance in which all the healers were invited to act. I observed that *Dzoca* healers did not dare to perform after their *Gamba* colleagues had successfully impressed the audience. Some

Dzoca healers whispered to the AMETRAMO president to complain that they could not mix with *Gamba* healers because 'we use a *Mutchira* and they use a bayonet . . . we use white clothes and they use red ones . . . they "ate people" and we did not.'

The AMETRAMO president – a *Dzoca* healer but a very insightful and pragmatic person – soon understood the winds of change in post-war Gorongosa and the progressive role played by the *Gamba*. He has engaged in this process himself by recruiting a *Gamba* healer to work as his assistant. When possessed by his innumerable healing spirits, this *Gamba* assistant has the reputation of diagnosing the problems of an entire audience. The golden years of the *Gamba* healers are gradually arriving in Gorongosa. However, the puzzle regarding the differences in the trance language of Shi-Ndau or Shi-Shona and non-trance Shi-Gorongose remain. So far, it is well known that Renamo's soldiers, at least those in the higher ranks of the military hierarchy, were Shi-Ndau native speakers. And during the war, one of their strategies for gaining control of the civilian population living in their controlled areas was to militarize them through the language. If a civilian could not reply in Shi-Ndau after being greeted by a Renamo soldier, s/he ran the risk of being labeled a *Capricornio*, meaning a traitor or spy working for the government army. In the 'best' of cases, torture would be the sentence and in the worst cases, death was the final solution.

Zimbabwean soldiers (locally referred to as *Ma-komeredes*) who were Shi-Shona native speakers were based in the Gorongosa region from the mid-1980s until about 1990. Although it is recognized that they had little contact with local populations, they nevertheless played a key role in the local dynamics of war. And for some population groups, the *Komeredes* were considered liberators because they destroyed the main Renamo military base and opened up several areas that had been under Renamo control for almost five years. In other regions, the Zimbabwean troops oppressed and killed civilians. The influence of Shi-Ndau and Shi-Shona in the Gorongosa region requires further investigation to gain more insight into the *Gamba* phenomenon. A quantitative study is also required to determine the prevalence of war survivors diagnosed with *Gamba*, as well as a more critical approach to the *Gamba* healers' interventions and the quality of their care.

Concluding Remarks

The increasing numbers of societies that have lived through war-torn situations demonstrate that in the post-war period there is a vital need to heal and thus stabilize society (Perera, 2001; Zur, 1998). There appears to be worldwide agreement on this point and little room for discussion.

However, the 'zone of disagreement' is about how the healing should take place. The different cases demonstrate that there is no single healing process applicable to all post-war societies. The healing process and the needs and priorities vary according to the degree of traumatization and the socio-cultural, political, historical and economic context. Probably the most interesting fact is that even within the confines of a single post-war society different healing processes can take place simultaneously. The case of Gorongosa is one example of this. It would be misleading to reduce the healing process in Gorongosa to the important and unequivocal contribution provided by the *Gamba* phenomenon. There are also other cultural processes providing important healing resources operating in the multiplicity of the social settings in which the Gorongosa people participate in their daily lives. Such resources include the agricultural cycle, the traditional system of justice and religious groups. A discussion of these resources and the processes they incur could not fit in the scope of this article but they form part of the ongoing longitudinal study and will be fully addressed and discussed in the future.

Acknowledgements

This study was supported by AEPATO. The author wishes to thank the AEPATO team in Gorongosa, and all the *Dzoca* and *Gamba* healers represented by AMETRAMO. Special thanks for the numerous families of war survivors. Extended thanks for the anonymous reviewers, and to Prof. Richters, Riedesser, Young, Machleidt, Sjaak van der Geest, and Rod Aya. I am also grateful for the support of dr. Ria Reis, Iraê Lundin, and Volkswagen Stiftung, WOTRO, LUMC, and ASC.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Press.

Barltrop, D., & Sandhu, B. (1985). Marasmus, 1985. *Postgraduate Medical Journal, 61*, 915–923.

Bolton, P. (2001). Local perceptions of the mental health effects of the Rwandan genocide. *Journal of Nervous and Mental Disease, 189*(4), 243–248.

Chingono, M. (1996). *The state, violence, and development: The political economy of war in Mozambique, 1975–1992*. UK: Avebury.

Cohen, S. (2001). *States of denial: Knowing about atrocities and suffering.* Cambridge: Polity Press.

Csordas, T., & Lewton, E. (1998). Practice, performance, and experience in ritual healing. *Transcultural Psychiatry, 35*(4), 435–512.

Das, V., Kleinman, A., Lock, M., Ramphele, M., & Reynolds, P. (2001). *Remaking a world: Violence, social suffering, and recovery*. Berkley: University of California Press.

de Girolamo, G., & McFarlane, A. (1996). The epidemiology of PTSD: A comprehensive review of the international literature. In A. Marsella, M. Friedman, E. Gerrity, & R. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 33–85). Washington, DC: American Psychological Association.

de Jong, J., Scholte, W., Koeter, M., & Hart, A. (2000). The prevalence of mental health problems in Rwandan and Burundese refugee camps. *Acta Psychiatrica Scandinavica, 102*, 171–177.

de Jong, J. T., Komproe, I., van Ommeren, M., El Masri, M., Araya, M., Khaled, N., van de Put, W., & Somasundaram, D. (2001). Lifetime events and posttraumatic stress disorder in 4 post-conflict settings. *Journal of the American Medical Association, 286*(5), 555–562.

Devereux, G. (1980). *Normal and abnormal. Basic problems of ethnopsychiatry*. Chicago: University of Chicago Press. [Original published 1956]

de Vries, M. W. (1996). Trauma in cultural perspective. In Van der Kolk, A. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 398–413). New York: Guilford Press.

Dolan, C., & Schafer, J. (1997). *The reintegration of ex-combatants in Mozambique: Manica and Zambezia Provinces*. Final Report. (Oxford: Refugee Studies Program). University of Oxford.

Eisenbruch, M. (1991). From posttraumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees. *Social Science & Medicine, 33*, 673–680.

Ellenberger, H. F. (1970). *The discovery of the unconscious: The history and evolution of dynamic psychiatry*. New York: Basic Books.

Englund, H. (1998). Death, trauma, and ritual: Mozambican refugees in Malawi. *Social Science and Medicine, 46*, 1165–1174.

Feierman, S. (1985). Struggles for control: The social roots of health and healing in modern Africa. *African Studies Review, 28*(2,3), 73–147.

Geffray, C. (1990). *La cause des armes au Mozambique: Antropologie d'une guerre civile.* Paris: Editions Karthala.

Hall, M., & Young, T. (1997). *Confronting Leviathan: Mozambique since independence*. London: Hurst.

Hanlon, J. (1991). *Mozambique: The revolution under fire*. London: Zed Books.

Harrell-Bond, B., & Wilson, K. (1990). Dealing with dying: Some anthropological reflections on the need for assistance by refugee relief programs for bereavement and burial. *Journal of Refugee Studies, 3*, 228–243.

Hiegel, J. (1994). Use of indigenous concepts and healers in the care of refugees: Some experiences from the Thai border camps. In A. Marsella, T. Bornemann, S. Ekblad, & J. Orley (Eds.), *Amidst peril and pain: The mental health and well being of the world's refugees* (pp. 293–309). Washington DC: American Psychological Association.

Honwana, A. (1998). Sealing the past, facing the future: Trauma healing in rural Mozambique. *Accord, 3*. London: Conciliation Resources.

Igreja, V. (2003) The effects of traumatic experiences on the infant–mother

relationship in the former war-zones of Central Mozambique: The case of *Madzawde* in Gorongosa. *Infant Mental Health Journal, 24*(5).

Igreja, V., Schreuder, B., & Kleijn, W. (1999). The cultural dimension of war traumas in central Mozambique: The case of Gorongosa. *Transcultural Mental Health On-line* (pp. 1–13). Available from http://www.priory.com/psych/traumacult.htm

Janes, C. (1995). The transformations of Tibetan medicine. *Medical Anthropology Quarterly, 9*(1), 6–39.

Janzen, J. (1992). *Ngoma: Discourses of healing in Central and Southern Africa.* Berkley: University of California Press.

Junod, H. (1934). Les cas de possession et de l'exorcisme chez les VaNdau. *Africa,* 7(3), 270–299.

Junod, H. (1996) *Usos e costumes dos Bantu*, vol 1 [The uses and costumes of the Bantu people]. Maputo: Arquivo Histórico de Moçambique. [Original published 1927]

Kirmayer, L. (2000). Broken narratives: Clinical encounters and poetics of illness experience. In C. Mattingly & L. Garro (Eds.), *Narrative and the cultural construction of illness and healing* (pp. 153–180). Berkeley: University of California Press.

Kleinman, A., Das, V., & Lock, M. (1997). *Social suffering*. Berkley: University of California Press.

Marlin, R. (2001). *Possessing the past: Legacies of violence and reproductive illness in central Mozambique.* Unpublished PhD dissertation, New Brunswick Rutgers, The State University of New Jersey.

Marsella, A., Friedman, M., Gerrity, E., & Scurfield, R. (Eds.) (1996). *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications*. Washington, DC: American Psychological Association.

Nathan, T. (2001). *La folie des autres: Traité d'ethnopsychiatrie clinique* (2nd ed.). Paris: Dunod.

Ngubane, H. (1977). *Body and mind in Zulu medicine*. London: Academic Press.

Nordstrom, C. (1997). *A different kind of war story*. Philadelphia: University of Pennsylvania Press.

Nordstrom, C. (1998). Terror warfare and the medicine of peace. *Medical Anthropology Quarterly, 12*(1), 103–121.

Perera, S. (2001). Spirit possessions and avenging ghosts: Stories of supernatural activity as narratives of terror and mechanisms of coping and remembering. In V. Das, A. Kleinman, M. Lock, M. Ramphele, & P. Reynolds (Eds.), *Remaking a world: Violence, social suffering, and recovery* (pp. 157–200). Berkley: University of California Press.

Reis, R. (2000). The 'wounded healer' as ideology: The work of Ngoma in Swaziland. In R. van Dijk, R. Reis, & M. Spierenburg (Eds.), *The quest for fruition through Ngoma: Political aspects of healing in Southern Africa* (pp. 61–75). Oxford: James Curry.

Reynolds, P. (1990). Children of tribulation: The need to heal and the means to heal war trauma. *Africa, 60*(1), 1–38.

Richters, A. (1998). Sexual violence in wartime: Psycho-socio-cultural wounds

and healing processes. The example of former Yugoslavia. In P. Bracken & C. Petty (Eds.), *Rethinking the trauma of war* (pp. 175–199). London: Free Assn Books.

Schafer, J. (1999). *Soldiers at peace: The post-war of demobilized soldiers in Mozambique, 1964–1996*. PhD thesis, St. Hugh's College, University of Oxford.

Schreuder, B., Igreja, V., Van Dijk, J., & Kleijn, W. (2001). Intrusive re-experiencing of chronic strife or war. *Advances in Psychiatric Treatment, 7*, 102–108.

Suárez-Orozco, M., & Robben, A. (2000). Interdisciplinary perspectives on violence and trauma. In A. Robben & M. Suárez-Orozco (Eds.), *Cultures under siege: Collective violence and trauma* (pp. 1–41). Cambridge: Cambridge University Press.

Summerfield, D. (1995). Addressing human response to war and atrocity: Major challenges in research and practices and the limitations of western psychiatric models. In R. Kleber, C. Figley, & B. Gersons (Eds.), *Beyond trauma: Cultural and societal dynamics* (pp. 17–29). New York: Plenum Press.

Tang, S., & Fox, S. (2001). Traumatic experiences and the mental health of Senegalese refugees. *Journal of Nervous and Mental Disease, 189*(8), 507–512.

Taylor, C. (1992). *Milk, honey, and money: Changing concepts in Rwandan healing*. Washington, DC: Smithsonian Institution Press.

Turner, S., McFarlane, A., & van der Kolk, B. (1996). The therapeutic environment and new explorations in the treatment of posttraumatic stress disorder. In B. van der Kolk, A. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 537–558). New York: Guilford Press.

Van der Geest, S., & Rienks, A. (Eds.). (1998). *The art of medical anthropology readings.* Amsterdam: Het Spinhuis.

Vines, A. (1991). *Renamo: Terrorism in Mozambique*. Bloomington: Indiana University Press.

Whyte, S. (1997). *Questioning misfortune: The pragmatics of uncertainty in Eastern Uganda*. Cambridge: Cambridge University Press.

Wilson, K. (1992). Cults of violence and counter-violence in Mozambique. *Journal of Southern African Studies, 18*(3), 527–83.

Young, A. (1983). The relevance of traditional medical cultures to modern primary health care. *Social Science and Medicine, 17*, 1205–1211.

Young, A. (1995). *The harmony of illusions: Inventing post-traumatic stress disorder*. Princeton, NJ: Princeton University Press.

Zur, J. (1998). *Violent memories: Mayan war widows in Guatemala*. Boulder, CO: Westview Press.

VICTOR IGREJA, MA, is a psychopedagogue, medical anthropologist and main war trauma researcher at Associação Esperança para Todos (AEPATO) in the former war-zones of Mozambique central. Currently he is also affiliated with the Leiden University Medical Center. *Address*: Leiden University Medical Center, Department of Culture, Gezondheid & Ziekte, Wassenaarse Weg 52, Pathologiegebouw 7c, 2301 CB, Leiden, P.O. Box 2083, The Netherlands. [E-mail: vgreja@yahoo.com]