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When the War Was Over, Little Changed

Women's Posttraumatic Suffering After the War in Mozambique

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Abstract: This article explores the psychosocial effects of women's prolonged exposure to civil war in the center of Mozambique. Using a combination of quantitative and qualitative methods, 91 women were assessed for posttraumatic stress symptoms and psychosocial indicators of ill health. The results indicate that for the majority of the women in this study, traumatic experiences are sequential processes. Their ill health ranges from symptoms of posttraumatic stress to episodes of spirit possession (*gamba*), affecting women's capacities to conceive and raise children, and marginalizing their social position. A careful analysis of the specific problems and needs of women in postwar contexts is recommended, along with a systematic examination of the effectiveness of the available resources that may play a role in boosting trauma recovery in this group of women.

Key Words: Women war survivors, posttraumatic stress symptoms, spirit possession, suffering, Mozambique.

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The recent history of Mozambique is characterized by nearly 3 decades of war. The struggle for independence went on from 1964 until 1974. One year after independence, the country became involved in a civil war between the Frelimo-led government and a rebellious movement named Renamo. This war lasted 16 years (1976–1992). It is considered to have been one of the most violent and brutal wars of the 1980s. The violence of the war was exacerbated by periods of severe drought (1988–1992), the outbreak of epidemics of cholera, diarrhea, and malaria, and the destruction of health care services.

The long-term effects of the various traumatic experiences remain largely unknown in Mozambique, although it is generally recognized that traumatic experiences in war can lead to the development of posttraumatic stress disorder (PTSD; American Psychiatric Association, 1994) and other manifestations of violence-related suffering (Sideris, 2003). There are exceptions. Some assessments have been made within specific groups, mainly groups of children that survived the war (Harris, 1994). Other studies were carried out among internally displaced populations and Mozambican refugees settled in different countries (Englund, 1998; Marlin, 2001). There is, however, still very little information on how those who could not flee, and were forced to experience various forms of violence during the long period of civil strife, lived through it, and dealt with their war experiences over time. In particular, the predicament of women exposed to war violence has been neglected in research.

Although violence against women in times of war and peace occurs repetitively worldwide, recognition of the psychological damage suffered by women is a relatively recent phenomenon. According to Van der Kolk et al. (1996, pp. 61–62), "between 1895 and 1974, the study of trauma centered almost exclusively on its effects on white males." The suffering of traumatized women remained almost unnoticed and was often transmitted from one generation to the other. While this gradually changed, the main focus was for a long time restricted to Western populations (Foa et al., 2000). War trauma experiences among nonwestern populations, particularly among women, still do not get the attention they deserve. The study described in this article is an attempt to fill this gap.

This study is part of a larger, ongoing community-based investigation into the long-term effects of violence and the resources available for recovery at the individual and community level. It was conceived 5 years after the end of the war (1997). The research location was a former war-zone in the center of Mozambique (Gorongosa). Most people were unable to flee and were forced to live within areas controlled by Renamo or by the Government. In Renamo-controlled areas, the population was living in their own residences (known as *Madembes*), while in Government areas the people were residing in communal villages. The common denominator in the two organizational systems was that people, in particular women, continuously suffered from extreme war violence, including sexual abuse and rape.

This article explores the scope and nature of women's suffering in Central Mozambique by (1) identifying the most overwhelming experiences of women during and after the war; (2) assessing the most prevalent posttraumatic stress symptoms; (3) studying various local manifestations of psy-

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chosocial distress, and their expression in behavior, language, and meanings; and (4) determining the availability of local resources to deal with the predicaments of women.

METHODS

A combination of quantitative and qualitative methods was used. The general procedure was to firstly recruit participants by organizing public meetings with the local chiefs and general population of two villages (Mucodza and Casa Banana), in which the purpose and design of the study were explained and voluntary participants were sought. Since the majority of women cannot read or write, they gave a verbal consent. Because the villages are small, almost every household could be reached, and the majority of the women insisted on participating in this study. For these reasons, no randomization technique was applied during the baseline measurements. The overall study involves men as well as women, but the focus of this report is mainly on the experiences of the women.

Participants

The participants consisted of 91 adult women who survived the war while living inside the war zones in the center of Mozambique. The social organization in the remote rural villages under study is patrilineal and based on a polygamous marriage system; the man is the chief of the household and is usually married to more than one wife. The people practice subsistence farming to survive. The socioeconomic conditions in the villages and of the participants are poor; their principal but meager financial income comes from the irregular selling of agricultural surplus once or twice a year.

Household surveys were conducted in both villages. The research team in the field consisted of the first author (VI) and four local assistants, who lived among the villagers in different periods totaling 14 months. This allowed the development of relationships built on trust, which in turn facilitated contact with the majority of women without the interference of their husbands or male relatives. None of the participants were promised a reward or received something in return for their contribution to this study. Their main motivation was to tell the research team their stories of suffering and surviving the war violence.

Research Instruments

Quantitative data were collected using standardized instruments. The total of 80 items can be divided into four sections: demographic data and war circumstances (9 items), shocking experiences (24 items), psychiatric morbidity (24 items), and posttraumatic stress symptoms (23 items).

Shocking experiences were measured by the trauma events section of the Harvard Trauma Questionnaire (HTQ). This part of the HTQ consists of 17 named events that can be rated as "experienced," "witnessed," "heard of," or "no." The HTQ was developed by Mollica et al. (1996), and was originally validated for use in a nonwestern population (mainly refugees from Far East Asia). The HTQ has subsequently been used in research with refugees from very different regions of the world.

Psychiatric morbidity was measured by the Self-Report Questionnaire (SRQ). The SRQ is a psychiatric screening instrument designed by the WHO Collaborative Studies for Extending Mental Health Care, and is comprised of two subscales: Neurotic (20 items) and Psychotic (4 items; Kortmann and ten Horn 1988). Questions can be answered by "yes," "no," or "?". The SRQ was validated in a non-Western population and has subsequently been used in numerous studies in different nonwestern societies (Deshpande et al., 1989). Because the SRQ was used as a continuous scale in this study (and not as a categorizing screening instrument), Cronbach α coefficients were calculated as measures of reliability. In the population under study, they were a satisfactory .82 for the neurotic subscale (SRQ-20), and a rather low .46 for the psychotic subscale. The latter subscale showed a highly skewed distribution of scores: 53% of participants had none of these symptoms and 25% reported only one. Because of these psychometric properties, the psychotic subscale was not used in the analyses.

Posttraumatic stress symptoms were measured with the Self Inventory for PTSD (SIFP). The SIFP measures symptoms according to the criteria used in the DSM-IV classification of PTSD. Items are answered in a Likert-scale format (1 = "not at all" to 4 = "extremely"). Reliability data have been published only for Western populations, with Cronbach α ranging from .92 (total) to respectively .83, .86, and .79 for the Intrusion, Avoidance, and Hyper-arousal subscales (Hovens et al., 2001). Similarly, these coefficients were calculated for our study population, showing respectively .86 (total) and .87, .71, and .71 for the subscales.

Validation of Instruments

Because our participants could neither read nor write, all items from these instruments were asked in the form of structured interviews. The validation process of these interviews was carried out during pilot studies taking place in multiple sites. Linguistic equivalence for each of the items of the questionnaire was established in Portuguese and Chi-Gorongose (Igreja et al., 2004b).

During the pilot study and in the early stages of the interviewing process, we found that several traumatic events mentioned by them were not covered by the HTQ list of events and were subsequently added (Table 1). On the other hand, some of the items of HTQ such as, for instance, "brainwash," appeared to have little validity for this population.

After validation of the PTSD questionnaire, it became clear that three items were not valid for our population, because of semantic problems or contextual nonequivalence. As a result, the new version consisted of 19 items, necessitating a change of the original cut-off point score for the determination of cases from $\geq$52 into $\geq$45. In multiplying the mean item score of the original cut-off score (2.36) by 19, a new cut-off score was obtained: $\geq$45.

Qualitative Method

The qualitative method consisted of in-depth interviews with women who had met the criteria for a PTSD case (66%: $N = 60$), and of ethnographic observation in the two selected communities. The interviews covered topics related to perceptions, meanings, and interpretation of war-related health and social problems, along with health-seeking behavior.

TABLE 1. Experienced Traumatic Events in Gorongosa Women ($N = 91$)[a]

	N	%
Original HTQ items		
Combat situation	91	100
Lack of food/water	91	100
No shelter	90	99
Close to death	84	92
Lack of medical care	82	90
Forced separation	70	77
Unnatural death (family/friends)	56	62
Lost or kidnapped	57	63
Physical torture	36	40
Murder of family/friends	44	48
Serious injury	9	10
Imprisoned	6	7
Murder of strangers	2	2
Sexual abuse[b]	2	2
Brainwashed	NA	NA
Added items[c]		
Loss of goods	91	100
Gandira (forced labor)	75	93
Lost or kidnapped family members	67	74
Ambushed	49	54
Could not perform *Ntsanganiko* (mourning ritual)	41	51
Could not perform *Madazwde* (ritual for infants)	40	50
Hide inside holes for shelter	37	46
Enter the cemetery many times	34	43
Not being able to produce in the field	21	26

[a]As measured by part one of the HTQ.
[b]Twenty-nine percent of the women responded that they had witnessed sexual violence.
[c]Due to missing values, the number of participants ranges from 91 to 80.

TABLE 2. Experienced Symptoms in Gorongosa Women ($N = 91$)[a]

		N	%
Item			
20	Easily tired	90	99
3	Sleep badly	71	78
6	To feel nervous, tense or worried	63	69
19	To have uncomfortable feelings in the stomach	62	68
2	To have poor appetite	61	67
1	To often have headaches	57	63
8	To have trouble thinking clearly	54	59
9	To feel unhappy	54	59
18	To feel tired all the time	51	56
7	To have poor digestion	49	54
17	To have thoughts of ending life	28	31
4	Easily frightened	27	30
23	Interference in thinking	25	27
12	To have difficult to make decisions	25	27
21	To feel somebody has been trying to harm you	23	25
10	To cry more than usual	23	25
16	To feel you are a worthless person	20	22
14	To be unable to play a useful role in life	20	22
24	To hear voices	18	20
11	To find it difficult to enjoy your daily activities	16	18
13	Daily work disturbed	12	13
15	To lose interest in things	8	9
22	Much more important person than most people think	6	7
5	Hands shake	5	5
25	To suffer with epilepsy	0	0

[a]Percentage yes answers as measured by the Self Report Questionnaire (SRQ-25).

RESULTS

Quantitative Data: Demographic Characteristics, and Degree and Type of Trauma Exposure

All participants were countrywomen living in communal village 1 ($N = 61$: 67%) and communal village 2 ($N = 30$: 33%). Ages had to be estimated and ranged from 22 to 60 years. At least 36% of the women lost their husband due to events of war or due to illness in a context of absence of health care facilities. The burden of war and disease also contributed to the death of 81 of their children. The majority of the children died of illness (84%), and 6% died as a direct result of war violence. Reported experiences are presented in Table 1, which clearly illustrates how highly exposed the women were to traumatic war events. From our list of 24 possible events, the women experienced a mean number of 21 traumatic experiences during the war.

Specific reported symptoms, measured with the SRQ, are presented in Table 2. A majority of the women felt very tired; had sleep problems, tensions, poor appetite, and headaches; and were in general feeling unhappy. From the interview data, it was also apparent that about a quarter of the women experienced feelings of being possessed by spirits.

Table 3 provides the means for the total SRQ and PTSD scales. The total SRQ score was high, resulting in 60% case classifications. All participants met criterion A of the DSM-IV PTSD classification, and 66% ($N = 60$) met the criteria for a PTSD case. The women scored very high on all three PTSD subscales. Table 3 also shows a significant correlation between very high scores on the symptom scales and a categorization of the women according to complaints of possession. Of the women complaining of spirit possession, 88% were also categorized as PTSD case ($\chi^2 = 6.70$; $N = 80$; $p = 0.008$).

Qualitative Analysis: Forced Labor, Spirit Possession, Nightmares, and Postwar Social Violence

While both the general and culture-specific types of traumatic events were experienced as very distressing, a specific form of forced labor (*gandira*) was reported as the most fiendish experience. Possession by war spirits (*magamba; single: gamba*) and nightmares were often mentioned as the most salient present problem or complaint. We observed also a lot of problems on the communal level: marital problems and postwar social violence. Most of these themes will be described in some detail, and are illustrated by short verbatim narratives as recorded from our informants.

TABLE 3. Mean Symptom Scales for Women Experiencing Involvement of Spirits

	All Women (N = 91)		Not Possessed (N = 55)		Possessed[c] Involved (N = 25)			
	M	*SD*	*M*	*SD*	*M*	*SD*	*t* (78)	*p*
SRQ[a]								
Psychiatric symptoms (total)	8.75	4.48	7.78	3.8	11.50	4.4	3.91	0.001
SIFP[b]								
Posttraumatic stress symptoms (total)	43.92	11.92	41.35	10.0	49.50	10.5	3.27	0.003
Intrusion	13.15	4.8	12.20	4.9	15.00	4.1	2.66	0.015
Avoidance	15.79	3.9	14.95	3.3	17.56	4.2	2.98	0.004
Hyperarousal	15.12	4.2	14.31	3.9	17.17	3.9	2.99	0.004

[a]The Self-Report Questionnaire (SRQ-20): sum of symptoms (range, 1–20).
[b]The SIFP: sum of symptoms (range, 19–76); PTSD case ≥45.
[c]Due to missing data not known for all women.

Gandira as a Specific Source of Trauma for Women

Forced labor (*gandira*)—such as carrying food, war ammunition and stolen goods—was used as a military strategy to support the Renamo war efforts. The penalty for refusing was punishment or even death. *Gandira* was devastating not only physically, but also psychologically, for although Renamo was heavily dependent on the people, its soldiers never hesitated to rape, torture, or kill the same people that they were relying on.

Although men also experienced the trauma of *gandira*, it was more traumatic for women, because for them it represented a radical sociocultural discontinuity in their role and place in society. For instance, when men and women were taken to perform *gandira*, there was a high probability that after reaching the unknown destination, the men would be sent back to their homes. The women, however, mostly remained in captivity in the surroundings of the bases, to feed the soldiers and to satisfy their sexual desires. *Gandira* was a constant threat to life, because along the way, people could fall into ambushes organized by the Government army. In addition, *gandira* was a permanently dehumanizing and violent experience, ultimately humiliating for everyone in the family and the communities. During *gandira*, women were separated from their families for days, weeks, or even months, and were heavily exposed to rape. In extreme cases, the women taken never returned home and were compelled to marry the soldiers who had abducted them.

The retrospective narratives of women about *gandira* are loaded with metaphors to express the "unspeakable": "I used to carry a weight much older than my age," "I used to carry luggage until the hair on my head was gone," "Renamo soldiers did not have lorries, so we were their lorries," or, "It was like our job." Rape experiences during the *gandira* lacked such metaphorical representations, although everyone described *gandira* as intimately connected to the rape of women. Most of the women confirmed their participation in *gandira*, but they opted to deny that the soldiers had raped them personally. One group of women usually stated that the soldiers preferred to rape young girls, while another group linked the rape to adult women. An adult woman stated:

". . . Before the soldiers raped a woman they looked to see if she was a young girl. They liked more the young girls. They wanted more the ones that did not yet have children; they did not want the elder women. Even if they knew that the father of the girl they wanted to rape was present, they did not care about it, and the father could not say anything. They used to say 'get out from here; I need your daughter to take a bath with me, and then to have sexual relations with her.' . . . We already knew that if you complained it was the same thing as selling your own life" (Maria, ±30 years).

On the other hand, it was common to hear young girls saying that they were not raped because at the time of the war they were still very young, and Renamo soldiers preferred adult women. Others even gave indications that they had managed to defy the soldiers: ". . . In the night when we were doing *gandira*, I used to hang myself in a tree. In this way, the soldiers could not do anything against me" (Carla, ±25). Alternatively, "I used to fight against the soldiers and they did not rape me." This type of denial, encompassing fantasies of resistance against the oppressor, was very evident; only four women stated they had been victims of rape. One of them asserted, "There is no single woman who did *gandira* and was not raped; all of them were raped by the soldiers" (Antonia, ±35 years). When Antonia was told that several women had said that they had done *gandira* but were not raped, she replied with vigor, "They are hiding, they are lying, that's impossible." *Gandira* and the rape it evoked are enshrouded with secrecy, shame, and silence. By stating that *gandira* was the most fiendish experience she went through, a woman implicitly uses *gandira* as a metaphor that refers to the violence of rape she was subjected to.

Gandira affected women also on the social level and seriously contributed to undermine the trust between husbands and wives. It subjugated women as relational beings in the communities, implying women's incapacity to control their bodies, and indicated that the families and society (represented by the men) had failed to protect them. Ultimately, *gandira* represented a dramatic disruption of the sociocultural norms that regulate the place and role of women in the Gorongosa communities.

Gamba Spirit Possession and Gamba Healers

About a third of the women reported suffering from spirit possession, in most cases (88%) accompanied by a high level of posttraumatic stress symptoms. These women asserted that "war spirits" prevented them from leading normal lives, and in this way for most of them "little has changed since the end of the war." These spirits are commonly designated as *magamba.* They mostly persecute and afflict women. *Magamba* are avenging spirits, mainly of young men, who were allegedly killed or died innocently during the war. There is a relative consensus in the society that *gamba* spirits emerged especially after the war, and are rapidly spreading throughout Gorongosa and center of Mozambique.

Everyone is afraid of *gamba* spirits, and the women affected by it can experience great suffering. The condition is accompanied by a set of psychosomatic symptoms; stomach and rib pain, strange pains in the whole body, headaches, poor appetite, sleeping disorders, nightmares loaded with persecution and sexual violence, irregular menstrual cycles, decreased interest in coitus, outbursts of anger, and general body weakness.

Spirit possession also has serious implications at the family and community level. The same spirit can possess other members of the family in different timeframes. The suffering can be distributed to the whole family, and for the work of healing the presence of the family and the community is necessary to provide support. In general, if a spirit possesses someone, this is a symptom of a serious problem that requires a specialized intervention provided by a *gamba* healer. Although the *gamba* spirits can cause havoc, they can also transform the psychosocial wounds of war survivors through the help of these *gamba* healers. The key features of the treatment are the following: (1) the *gamba* healer induces the patient into a state of possession by the *gamba* spirit, in which state the spirit re-enacts, through spoken discourse and violent body movements, the past wrongs suffered by it; (2) the healer, together with the patient's family, acknowledges the past wrongdoing to the *gamba* spirit; (3) in turn, the *gamba* spirit demands reparation as a trade-off for leaving the patient's body; (4) the patient's family, under the supervision of the healer, must repair the spirit's claims; after this, the spirit leaves the patient's body, which paves the way for recovery.

Sleep Disturbances

Sleep disorders were among the less difficult symptoms to diagnose. Right from the start of the study, nearly every woman complained of sleeping problems exacerbated by frightening dreams. Women very often explained, "It's very difficult to sleep. Sometimes I sit down with no sleep until the cock begins to crow. I turn to one side and then to the other. I just cannot manage to sleep. Sometimes when I get inside my hut everyone sleeps except me" (Marta, ±30 years). The bad dreams of women can be divided into two types: dreams with a culturally oriented content, and dreams with war content. Each type is illustrated here by an example.

"I have many bad dreams. Sometimes I dream that I am crying and after that, I see something happening in real life. For instance, I take someone to the cemetery to bury him or her. Other times, I dream that I am cultivating. I dream of fire. I dream that my child is dead, but when I wake up she is still alive. I dream I am digging holes in the ground. These frightening dreams are causing me a lot of suffering. I dreamt that I gave birth to a child, but when I wake up there is no child. Sometimes I dream that people are giving me a child and when I wake up I do not see this child" (Antonia).

"I dream that soldiers are shooting weapons to hit us and we run away. I dream that we are running away and I try to put my child on my back and I fail to do it. I dream that soldiers are tying me up . . .. I dream that the war is coming and then I ask 'will we be saved?' I dream that we are running away, the soldiers are shooting their weapons, and people are being shot dead. I dream that I am walking in the bush, carrying luggage on my head. When I wake up my heart beats a lot because of these dreams. Sometimes I think that what I dreamt of is about to come back again. I feel weakness" (Josefa, ±28 years).

Underlying the two types of dreams is a general cultural belief that dreams play a prognostic role. Following a bad dream, people ruminate on the possibility that the dream content could take place in real life. Therefore, an intervention becomes necessary to prevent possible misfortune occurring. Normally the traditional healer is the first therapeutic choice for such interventions. An exception to the prognostic role was found in another type of dream: nightmares of violent sexual assaults. These are not interpreted locally as referring to something that will happen in the future, and the exegesis made of them is also different.

Historically and culturally, dreams are part of people's daily lives. Dreams have meaning and before responding to them, the meaning needs to be decoded and interpreted. However, when the content of the dreams is related to war events, the meaning is very clear and does not require a lot of intellectual expertise. With war-related nightmares, women become stressed, confused, and disoriented. They think that the war will come back, but also realize that traditional healers do not have the appropriate medicine to prevent this (and other overwhelming events) from happening. Consequently, when people dream about their war experiences, they get into a high state of alert, watching for any signs of another war in their surroundings so that they can flee. People often say, "If I see that the war is coming back again, I will be the first one with my family to run away, and we will run to somewhere far away."

But with the passage of time, the removal of landmines from the fields and the re-establishment of the agricultural cycle, and also through several public and private meetings conducted by the first author with local assistants, war survivors in Gorongosa began realizing that the war had in fact ended forever, and that the events in their posttraumatic dreams would not take place in real life.

Nightmares With Themes of Sexual Assault

Sexual violence occurring during nightmares is also interpreted within cultural boundaries, but is not given a prognostic value. Several women dreamt about being violently sexually assaulted by a man, but they very seldom managed to see his face. Although the women did not talk about their personal wartime rape experiences, they were prepared to share in detail

their nightmares concerning rape. Apparently sexual violence is not a taboo subject when it occurs in the form of nightmares. The interpretation of these nightmares is that the dreams are the spirits of dead people coming to assault the women concerned. Accordingly, these dreams are not experienced as a replica of anxiety and extreme fear felt during wartime. An example can help to illustrate this issue.

"Sometimes I dream about a man who comes to have sexual relations with me, I begin to scream and I run away. After quite a distance, I found a military base full of soldiers. Then, two soldiers came near to me, they began to beat me, and they said 'come to sleep with us.' I told them 'I have already a husband.' They said 'Aren't we men too.' Then they assault me to have sexual relations and I wake up. When I wake up I am very scared, and my heart beats a lot" (Maria).

Attempts to establish a link between this kind of dream and what might have actually happened to the person concerned during the war were unfruitful. Women and society in general deny such a correlation and during the interviews, women immediately refused to consider any such link.

Deteriorating Intramarital Relations, Family Instability, and Infertility Problems

The consequences of war are also observed in intramarital relations. Two main causes were identified: spirit possession and the effects of *gandira*. The postwar spirits are experienced as vengeful and very powerful. They afflict living people individually through uncontrolled states of possession, nightmares and other related symptoms, but can also impede the potential of women to fulfill their role in society, i.e., to have functioning families and conceive children. Locally, women's difficulties in conceiving children (primary or secondary infertility) or properly nursing children are interpreted as being caused by the malevolent action of spirits. Our observations indicate that unless the spirits are successfully treated, spirit possession directly contributes to marital conflicts.

Women possessed by spirits have unstable relationships with their husbands; they are not respected and lose their self-esteem. Unless the possession by a spirit is interpreted as a positive call for the person to work as a healer, spirit possession can contribute to tearing apart the family. The result can be divorce or multiple divorces; 50% of the women reported a history of more than three divorces. This is not the normal pattern for a society in which marriage was a strong institution and involving a complex set of rituals of respect. Historically marriage did not consist of a simple union that could culminate in divorce if the woman was possessed by a spirit. Because very few men remain with their wives when they discover that they suffer from spirits, these women get married to several men. They "travel" from one *ku banja* (parent-in-law's house) to another without success.

Another cause of marital instability is related to the aftermath of the *gandira*. As a result of *gandira* experiences, several men have serious difficulties in trusting their wives or women in general. They are quick to accuse their wives of extramarital sexual intercourse and can become very aggressive. One of our informants said,

"Life with my husband is not good. I cannot go out of my house to talk with other people. My husband says that if I go out to talk with other people I will get another man, as it used to be during the time of *gandira*. Every time I go out he beats me, often in the head, and I do not hear very well now. I always wish I could go to my parents' house, but, unfortunately, they are all dead. I have no close relatives" (Joana, 35 years).

This narrative mirrors the experiences of several women in this study. In the past the family was a powerful resource that used to buffer the impact of overwhelming experiences. This was seriously undermined by the prolonged exposure to war. This is demonstrated quantitatively by the figures indicating that half of the women categorized as PTSD case had a history of at least three divorces.

The present psychosocial suffering of the women is directly related to their war experiences, but also to the fact that physical or psychological violence still take place. After the war, some husbands agreed to continue living with their wives, while other women had to move from the war location to other places where they began a new life. In most of these cases, female war survivors are not considered as married, but to have been adopted by men. Several women declared that their husbands did continue living with them because they as women did not have any other place to go after the war. These women do not receive the treatment that a married woman, socioculturally speaking, deserves. The husband may not beat her, but in fact stigmatizes her within the household. Men who married after the war give much better treatment to their wives who do not have a history of *gandira* exposure.

Neither men nor women dare to narrate rape experiences, but everyone knows that this traumatic reality was linked to *gandira*. Some men recognize that the rape of their wife was beyond her control and power, but still want to get rid of this tremendous sense of humiliation. Other men consider that a number of women slept with the soldiers during the war with the women's consent. One of the men's strategies for conveying their painful, secret memories is to stigmatize women in silence. In such circumstances, women live under permanent distress, always facing family troubles and community distrust.

Physical Violence Within the Community

Women were targeted during the war, but still remain the main targets of the violence that is generated at the community level. There seems to be a relationship between the general decreased in value placed on the death of someone, and a high probability that women will be easily accused of such a death, which is followed by the infliction of violence upon those women. We came across various cases of violence directed to women in public space, and with hardly any interference by bystanders. These cases were indicative of women's ongoing experience of hardship and suffering many years after the war. Although with less intensity when compared with the wartime period, traumatic events are still an integral part of their current experiences in this postwar period.

DISCUSSION

The main objective of this study was to describe the war experiences of women living in remote villages in former war zones in the center of Mozambique, and to analyze their postwar symptom levels and current problems.

The results indicated that these women were heavily exposed to the war. The use of the HTQ showed the reporting of many traumatic experiences. The use of narratives to recollect women's experiences allowed us to acquire in-depth accounts of those wartime and postwar experiences. These narratives indicate that women were one of the main war targets of all the armies that fought in Gorongosa. In particular, being forced to work for the soldiers (*gandira*), often resulting in the sexual abuse of the women, was frequently mentioned as one of the most traumatizing experiences. *Gandira* accompanied by rape and the consequent radical dislocation of women's place in society was so pervasive that even 10 years after the war, women were still paying for these experiences.

Because of the war, women in Gorongosa are suffering from different types of psychosocial and psychosomatic symptoms. Their ill health in general is consistent with the PTSD symptoms described in different clinical and social contexts, which also point to the pervasive effects of violence against women (Clum et al., 2001; Taylor and Janson, 2001). Yet the PTSD symptoms are not enough to portray the magnitude of the Gorongosa women's suffering and sorrow. It is important to add the spiritual, family, and community dimensions that wreak havoc in their lives. Very often, after the structured assessment of PTSD and SRQ symptoms, women asserted that their real problems were the ones being caused by the spirits.

The easiest symptom to diagnose is sleep disturbances and nightmares. Yet the models used to understand and to explain these symptoms vary according to sociocultural context. For instance, women in Gorongosa regarded their nightmares not as a posttraumatic effect of their wartime experiences, but as the result of the war spirits (*gamba* and other spirits) that possess their bodies. *Gamba* possession is so overwhelming that the consequences are far-reaching. This result is consistent with studies of the predicament of women after prolonged and multiple war exposure in other geographical regions of Mozambique where spirit possession is also a common form of expressing different types of health problems, social afflictions, and the consequences of exposure to extreme communal violence (Marlin, 2001[1]; Sideris, 2003). The appearance of the *gamba* spirits was accompanied by the emergence of *gamba* healers. Therefore, *gamba* has two sides: one of affliction and destruction and another of potential resolution (Igreja, 2003b).

Individual and Social Suffering: A Sequential Experience

Everyone agrees that peace was the best thing to have happened in the last hundred years in Gorongosa and in Mozambique in general. The narratives and feelings of women, however, convey also a message that peace has been a time of permanent accumulation of frustration and a struggle to ward off war spirits and to regain the trust of the community. This has not been an easy task in Gorongosa, nor elsewhere (Marlin, 2001; Sideris, 2003).

The recently growing number of studies on women and traumatic stress indicate that women's exposure to traumatic events has profound consequences not only on the individual level but also for their families and communities (Meintjes et al., 2001; Politkovskaia, 2003; Richters, 1998). The women in this study performed various key roles, although mainly in the confines of the family. The group of female healers represents an exception. They have the freedom to operate in other sectors of the community life. The most popular ones can also work in transnational spaces (Igreja, 2003b). The traditional division of labor and the specific roles attributed to ordinary women had consequences for their exposure to war violence and male brutality, as well as for the continuum of suffering and burden appearing subsequently in the postwar period. In this regard, the suffering of women is sequential and extends to their families. This is because when a woman gets ill or possessed, there are household activities that are compromised, in particular sexual intercourse and reproductive capacities, which often frustrates their husbands. Everyone in the family is affected, and for this reason the whole family has to participate in health-seeking strategies.

Help-Seeking Behavior and Healing Resources

The majority of women in this study asserted that the main institutions that could provide relief for their problems were traditional medicine and religious healers. It is part of the cultural norms and practices that spiritually related problems, which have implications for their physical health and family and social relations, are solved by traditional healers or by religious healers who use healing methods to a certain extent similar to the traditional medicine.

Economic factors play a role in the help-seeking behavior in the sense that healers differ in quality, and those with good reputations based on intervention-effectiveness tend to be more expensive. Since people have the tendency to do what the French call *nomadisme medical* (to shop around for health assistance), and since the people in Gorongosa do not have health insurance, this process is a heavy burden on the women's family. In this way, the level of financial resources available in a woman's family strictly limits the *nomadisme medical*, which in turn may have a negative effect on obtaining a comprehensive diagnosis of the health problems and related interventions.

The narratives showed that women's problems do not go unrecognized. The community, in joint efforts with healers, created a new label (*gamba* spirits) that facilitates the recognition of some of the problems that emerged as a result of the war. Women suffering with *gamba* spirits have to be assisted by a *gamba* healer, most of whom are female. The new *gamba* healers, in contrast to the old type of healers (*dzoca* healers), became the main source of health care assistance for these women. The *gamba* healers nowadays play a central role in providing health assistance to the individuals and families in the center of Mozambique (Igreja, 2003b). In addition, the *gamba* phenomenon became so

generalized that religious healers also integrated this category of spirits in their diagnosis and healing language and practice.

CONCLUSION

The war had profound long-term consequences for women and society in general. Health complaints and extreme family conflicts seem to be generalized in the center of Mozambique. However, these problems do not go unrecognized; the etiology of women's ill health generally is attributed to the actions of the *gamba* spirits. The specificity of the *gamba* healers' work reflects the availability of local resources (Igreja, 2003b). What is required now is a systematic study of the effectiveness of these resources. We found that women are complaining because of their present predicament, yet in principle there are resources available in Gorongosa to deal with their suffering. It is important to carefully study where the apparent failure to thrive is coming from. Is it because women expect immediate results while the magnitude of their traumatic suffering requires more time for effective results? These and other topics require a long-term and systematic investigation to provide clear answers concerning the issue of effectiveness of healing resources in postwar Mozambique.

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REFERENCES

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th ed). Washington DC: American Psychiatric Association.

Clum G, Nishith P, Resick P (2001) Trauma-related sleep disturbance and self-reported physical health symptoms in treatment-seeking female rape victims. *J Nerv Ment Dis*. 189:618–622.

Deshpande S, Sundaram K, Wig N (1989) Psychiatric disorders among medical in-patients in an Indian hospital. *Br J Psychiatry*. 154:504–509.

Englund H (1998) Death, trauma and ritual: Mozambican refugees in Malawi. *Soc Sci Med*. 46:1165–1174.

Foa E, Keane T, Friedman M (Eds) (2000) Effective treatments for PTSD. London: Guilford Press.

Harris J (1994) Children of war and children at war: Child victims of terrorism in Mozambique. In R Ursano, B McCaughey, C Fullerton (Eds), *Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos* (pp 287–305). Cambridge: Cambridge University Press.

Hovens J, Bramsen I, van der Ploeg H (2001) Handleiding bij de Zelfinventarisatievragenlijst Posttraumatische Stressstoornis (ZIL). Lisse, Swets & Zeitlinger.

Igreja V (2003b) "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. *Transcult Psychiatry*. 40:459–487.

Igreja V, Kleijn W, Schreuder B, van Dijk J, Verschuur M (2004b) Testimony method to ameliorate post-traumatic stress symptoms: Community-based intervention study with Mozambican civil war survivors. *Br J Psychiatry*. 184:251–257.

Kortmann F, ten Horn S (1988) Comprehension and motivation in response to a psychiatric screening instrument: Validity of the SRQ in Ethiopia. *Br J Psychiatry*. 153:95–101.

Meintjes S, Pillay A, Turshen M (Eds) (2001) *The Aftermath: Women in Post-Conflict Transformation.* London: Zed Books.

Mollica R, Caspi-Yavin Y, Lavelle J, Tor S, Yang T, Chan S, Pham T, Ryan A, Marneffe D (1996) *Harvard Trauma Questionnaire (HTQ): Manual Cambodian, Laotian and Vietnamese Versions. Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, Supplement 1.

Politkovskaia A (2003) *Tchetchenie: Le deshonneur Russe.* Paris: Buchet/Chastel.

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. 112–128). London: Free Association Books.

Sideris T (2003) War, gender and culture: Mozambican women refugees. *Soc Sci Med*. 56:713–724.

Taylor R, Jason L (2001) Sexual abuse, physical abuse, chronic fatigue and chronic fatigue syndrome: A community-based study. *J Nerv Ment Dis*. 189:709–715.

Van der Kolk B, Weisaeth L, van der Hart O (1996) History of trauma in psychiatry. In B van der Kolk, A McFarlane, L Weisaeth (Eds), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society* (pp 47–74). New York: Guilford Press.

END NOTE

Marlin R (2001) *Possessing the Past: Legacies of Violence and Reproductive Illness in Central Mozambique.* PhD thesis. New Brunswick, New Jersey.