CHAPTER 12

Bad Times and Sad Moods*

ALOK SARIN, SARAH GHANI AND SANJEEV JAIN

Abrupt and sudden dislocation, loss of social rootedness and exposure to social unrest have all been identified as causes of trauma. It is now also widely accepted that such trauma can make people more susceptible to developing physical and mental health problems. There has been considerable documentation of the long-lasting effects of politically motivated violence, on both victims (Schick et al. 2013; Sharon et al. 2009) and perpetrators (Bayntun 2005). The partition of India in 1947 was accompanied by large-scale migrations, violence and the breakdown of established civic life in large parts of the region. While this can be seen as part of the general shifting of populations in the post-World War II reorganisation of 'national boundaries' in Europe, its effects on the newly decolonised regions in Asia and Africa were vastly different. These emerging states did not have the adequate administrative or medical infrastructure to cope with this unprecedented transmigration, especially since this was attended by horrific acts of violence, looting and sexual assault.

While the Holocaust, the disintegration of Yugoslavia (Kunitz 2004) and violence in Africa have been associated with high rates

* This work was supported in part by a grant from the Wellcome Trust, 'Turning the Pages' (096493/Z/11/Z). The immense help of Prof. Pratima Murthy, Prof. P.S.V.N. Sharma and Dr P. Radhika is gratefully acknowledged, as is the participation of all the respondents to the questionnaire, with whom we plan to have further conversations.

of trauma and disease, other events such as the reunification of Germany (Achberger, Linden and Benkert 1999) do not seem to have resulted in any major impact on mental health. There is, however, very little literature in the medical field on the impact of political violence on mental health parameters in the 'developing' countries of the Third World.

In the specific context of India, partition was accompanied by significant difficulties of both mental and general health. There was widespread violence, the death of about half a million people (estimates vary widely), and significant physical and sexual assault, arson and looting as well as the destruction of property (Brass 2003). It was against this backdrop that the largest transmigration of people in human history took place, and it is estimated that upwards of 15 million were moved across the new borders in traumatic and tumultuous circumstances (Kamtekar 1995; Khwaja, Mian and Bharadwaj 2008). The available infrastructure to either control the violence, or support the migration and 'resettlement' of the refugees was woefully inadequate; the magnitude of the phenomenon had clearly been underestimated, and apparently 'unexpected' (Shone 1947). There is considerable documentation of the migration and translocation, as well as the acts of brutal and inhuman violence in which both major religious communities were equally victims and perpetrators. The likelihood that this would cause psychological impact in the short and the long term seems obvious (Portney 2003). Intriguingly, however, there is little documentation or exploration of this kind of psychological impact – something that seems strange for what was clearly a phenomenon of some magnitude.

Over the past decades, there has been increasing awareness of the 'silence' regarding this event (Butalia 1998), and awareness of its long-lasting psychological consequences has also grown. In the absence of any public acknowledgement of the trauma, or an understanding of its reasons and how it can be addressed, most individuals and families have coped as best as they could. The absence of any discussions about these events, and their impact on health, has led to a spiral of silence, so that the impact of subsequent political violence on social parameters (including health services) or psychological health is also largely absent from the public gaze. The

human cost of these is, thus, not understood, and no interventions are planned.

In recent times, however, we have seen a growing awareness of the 'inter-generational transmission of trauma' (Portney 2003). While most of the available literature on this focuses on victims of the Holocaust, it stands to reason that other traumatic experiences, like that of the violence linked to partition, would be just as likely to lead to such intergenerational transmission of trauma. There are important differences to note though: unlike the violence of the Holocaust, violence during partition was not restricted to a particular community or class. Both of the large subcontinental communities were perhaps equally victims and perpetrators in acts of brutality.

Adequate descriptions and first-person accounts of the events during partition are now publicly available. One might, therefore, ask: had psychiatric and counselling services been available at the time, would the nature of trauma and emotional distress have been recognised? While it is certainly important to consider what kinds of models of intervention would be considered, if they had been available, it is perhaps also appropriate to start conversations on how a larger awareness of these issues would have influenced subsequent historicity.

Apart from this, we also need to explore the frameworks that mental health professionals would use to assess the impact of political violence and communal conflict, specifically on the recognition, intervention and 'understanding' of the symptoms described by individuals.

OBJECTIVES AND METHODOLOGY

The main objective of this essay is to interrogate the understanding of mental health professionals regarding the psychological aspects of communal conflict. To this end, we attempt to see whether experts read into narratives of communal conflict a mental health issue, whether they think this constitutes mental disorder, and to see what interventions, if any, they would have deemed appropriate. We also hope, by this enquiry, to begin some conversations on how psychological trauma and communal conflict are related.

We developed 15 vignettes (see Appendix 1) from first-person accounts of people who have experienced political violence. The majority of these are abstracted from publicly available first-person accounts (1947 Partition Archive 2013; Butalia 1998) of people from India and Pakistan who experienced partition, and also Indians and Pakistanis in the United States who migrated there afterwards. We also included five first-person accounts from the Hutu–Tutsi riots in Rwanda (Cultures of Resistance 2011; Rwandan Stories 2013), which were characterised by both political and religious violence. We have anonymised these and removed all reference to time, context and geography. Each vignette had four identical questions about the diagnosis, treatment and therapy (both medical treatments and psychotherapy), and did not include any information about the social or political background of the people.

An outline of the proposed study was circulated to a mailing list of psychiatrists and other mental health professionals, comprising around 450 members, asking their willingness to participate. Fifteen practitioners responded, and they were then mailed the full questionnaire including the case vignettes and the queries. Of these, a total of 13 completed the questionnaire.

The enquiry is intended as a first step in constructing a dialogue with mental health professionals to explore thinking about mental health issues around communal strife and political violence. In this essay, we analyse the responses to the questionnaire and discuss these.

RESPONSES AND RESULTS

The respondents were requested to reflect on the following:

1. Whether they would consider a psychiatric diagnosis in a particular case, and if yes, offer one?
2. What sort of intervention would they offer?
3. Would they offer pharmacotherapy (intervention with medication) or psychotherapy (intervention with 'talk therapies'), or a combination?
4. What kind of therapy would be suitable (brief dynamic,

interpersonal, cognitive behaviour therapy [CBT], client-centred or some other)?

We found that the almost all mental health professionals felt the people in the vignettes were suffering from psychological problems and that they required professional help. Nearly 80 per cent said the people were suffering from post-traumatic stress disorder (PTSD). The rest felt that they had adjustment disorder, depression, major depressive disorder and agoraphobia. A few (two) did not feel like giving a diagnosis. The vast majority (90 per cent) felt that a combination of psychotherapy and pharmacotherapy would work best. The others suggested that either only psychotherapy or family therapy would work, or that only pharmacotherapy would work. A few (two) also felt that a specific treatment called eye movement desensitisation and reprocessing (EMDR) and emotional relieving under barbiturate anesthesia should be used (a form of abreaction or catharsis under medication). More than two-thirds of the professionals felt that among therapies, CBT would work best. The rest felt that interpersonal therapy, supportive therapy, EMDR, client-centred and group therapy would work.

DISCUSSION

It is interesting that a majority of mental health professionals saw in these vignettes of trauma, diagnosable and potentially 'treatable' psychiatric disorders. There was near unanimity on this score. Most offered specific interventions. This in itself throws up several questions that we think need to be further explored.

The Recognition of Disorder and the Thinking of Diagnosis

Most of the respondents were of the opinion that the individuals described were suffering from mental health issues that could benefit from intervention. These diagnoses ranged from PTSD to adjustment disorder and depression. In this, they were following current diagnostic trends, as the symptoms and behaviours described, that fall within the ambit of mood and behavioural disorders as

defined by diagnostic systems like DSM-5 and ICD-10 (American Psychiatric Association 2013; WHO 2007). However, this raises larger epidemiological questions of the validity of construct and prevalence. These accounts, in themselves, represent a minuscule fraction of those who lived the experience, as do also the number of mental health professionals who responded to the survey. While it may not be methodologically appropriate to extrapolate from these limited numbers, it is quite apparent that the symptoms and idioms of distress were expressed and recognised. Thus, it can be estimated that a significant proportion of those who experienced these events did, and may continue to have, mental health issues.

The fact that trauma caused psychological distress is obvious. It is only when we begin to ask whether this distress, which is the 'understandable' response to trauma, constitutes disorder, that questions begin to emerge. Interlinked with these are the nature, severity and duration of the distress that the trauma causes, as also aspects of the trauma itself. There is some work that seems to differentiate between trauma caused by natural and 'man-made' factors. In a study of individuals 20 years after exposure to political violence, almost half had anxiety symptoms, a third had depressive symptoms, while 20 per cent met the full criteria for PTSD (Eisenman et al. 2003; Sabin et al. 2003). Such long-term sequelae have rarely been investigated in response to 'natural disasters', though persistent effects were noted among tourists (Kraemer et al. 2009) and resident populations up to three years after the tsunami of 2004 and for many years after the Chernobyl disaster. Detailed analyses that compare resilience or coping strategies following these disparate kinds of stress have not been commented upon, although a convergence to cause even greater occurrence of PTSD, following 'man-made' trauma has been noted (Catani et al. 2008).

The second question is about the psychiatric conceptualisation of trauma. It has long been known that the categories of adjustment disorder and PTSD are among the common diagnoses made in psychiatric practice. It has also been recognised that the present diagnostic categorisation of PTSDs is, at best, both limited and preliminary. The World Health Organization's attempt to differentiate between PTSD and a related but distinct category of an enduring

personality change after a catastrophic experience (classified as F62.0)—which some of these subjects clearly seem to have described—is a move to understand the nuancing of the different ways in which difficult situations influence people (Maercker 2013). While this may not necessarily be the best platform for a detailed exploration of the concepts of psychiatric diagnoses, it is obvious that the dialogue with social science is an essential ingredient for informing this debate.

A related issue is the trans-generational transmission of the effects of this. Many studies have commented on psychological issues among the children of those who experienced the Holocaust (Portney 2003). We have not specifically addressed this here, but if those estimates were extrapolated to the South Asian situation, where several million went through a traumatic experience, the figures may be quite large. Thus, we feel that the ways in which such events impact our lives – not only in terms of numbers of people, but also how social relations, the processes of psychological myth making and societal stereotyping are affected, needs to be thought about.

Professional Silences

These are issues that mainstream psychiatry seldom addresses. So professional forums and psychiatric publication is largely silent on this. In a sense, this is may be why, despite the invitation to 450 members, 15 evinced interest, and only 13 participated. An interesting question that arises is the possible reasons for these professional silences. Various explanations have been offered.

Is this insensitivity to 'psychological' processes? With the growth of the biomedical gaze in science, it may perhaps be a reason, though when these rather cataclysmic events occurred half a century ago, both biomedical and psychological gazes were perhaps equally important, at least in the developed world. However, the medical profession in India at that point was preoccupied with infective and somatic disease, and social and psychological antecedents of disease and distress were not commonly debated. These issues were not prominent in the wider political discourse either. So this may be

part of the explanation for this neglect, although, perhaps, not a sufficient one.

Is this an aspect of the rather inadequately informed 'colonial' mindset that has characterised psychiatric thinking? The inner life of the individual, which is often the subject of scrutiny in contemporary psychology (psychoanalysis, existentialism/humanism, cognitive neuroscience) was not considered relevant to the specific person under colonial rule. Thus, communitarian identities (martial race, tribal, caste, or regional – Arab, Pashtun, Tamil, Bengali – and finally religious identities) were thought sufficient to explain both subjective experiences as well as the overt behaviours of individuals. A shared, common experience of distress and trauma to social events, thus, could not be envisaged. While this remains a possibility, we feel that this is certainly an area that needs to be further explored.

Is this part of a 'psychological blindness'? Psychiatry, while a medical discipline, is the most socially rooted and dependent of all the medical specialties. In India, as also in other parts of the world, the rules under which psychiatry operates have often been identified with political processes. This ranges from the attitudes to the 'African mind', to the neglect of psychotherapy in India (Jain and Sarin 2000), to the actual abuse of psychiatric terminology (Kecmanović 2002; Weine 1999). So it may perhaps not have been only individuals suffering from the consequences of trauma, but, indeed, society. The subsequent silences across the board may be a reflection of this.

The consequences of this inattention could, however, have been quite significant. The non-recognition of the biggest 'elephant in the room (partition-linked violence)' also led to the under-recognition of the traumas and the consequences it engendered in subsequent decades. The spirals of violence that have followed, due to the persistence of ethnicity, religious, linguistic and caste-based politics, were never addressed as causing a definite personal and health impact, which would then need interventions. In any case, health, especially mental health, was never viewed as an organic correlate of social health, and the system could thus afford to ignore the psychological impact of this partitioning of minds and hearts.

Interventions

The third question is that, regardless of diagnostic category, if obvious distress is seen as causally related to traumatic events, what is the best intervention that can be offered? The answer would very likely depend on whom the question is addressed to. It is clear to us that the interventions will have to include measures of rehabilitation and social support, without which psychological intervention becomes meaningless. If, for the purpose of this discussion, we were to focus on mental health interventions, the nature and variability of the interventions offered is itself interesting. Across the board, psychological therapies clearly find a more central place, with a choice between cognitive behaviour therapy, interpersonal therapies and family therapies. These, we feel, probably reflect the individual predilections of the professionals in question. It is also interesting that only a few (medically trained professionals) suggested pharmacotherapy.

There is considerable debate about the nature of interventions. These arise from the observations of differences in rates of PTSD across ethnic groups, and the influence of family and social factors. It has been suggested that the social and psychological consequences of violence be anticipated, especially when there is likely to be community destruction or displacement (Norris 2009). Some authors highlight inherent community coping strategies, while others highlight the provision of services. In the context of partition, the nature of the 'community' was redefined along partisan lines and the services of assistance (medical and social) were dismembered, thus making any help near impossible. These processes, in a sense, continue, with the rather extreme example of accusations of doctors of one community being inimical to the other (Varshney 2001), being potent tinder to escalate violence. The converse, that medical and mental health services are avowedly non-partisan, is neither emphasised nor, apparently, taken for granted.

The fourth question is related to the queries raised by some people to whom the questionnaire was sent. The fact that awareness of the particular events and contexts is necessary for a more complete understanding of individual distress is quite evident.

Thus, an understanding of the individual story, with its sociocultural rootedness, what is called 'pre-morbid' functioning, the nature of the traumatic event, the availability of different forms of support, and the duration of the persisting 'symptom', are probably important. However, there is little in the education and training, or research, in the Indian mental health services that addresses the historical origins, interactions or consequences of political events on psychological health. Attempts to understand the specific nature of each individual event/personal account could thus transmute into a limited 'local' understanding, leaving the larger social (universal) context unaddressed.

In summary, we feel that there is a need to evaluate the psychological aftermath of partition. This would allow us to better understand the nature of the trauma and its consequences, and also encourage debate about the interface between individual mental health (well-being and sense of autonomy) vis-à-vis historical, social and political processes. Psychiatric services, as the primary resource for both help and debate, need to address these issues.

APPENDIX 1

Vignettes

Vignette 1

A 45-year old man has a sense of despair, chronic feelings of frustration, anger, hatred and emotional detachment. He saw his best friend being killed, and this moved him to the core. He didn't understand what was happening and why. His family, seeing his condition sent him away to a relative's home, but his symptoms and behaviour only got worse. He began having recurring nightmares and flashbacks. The loss of his friend, and the shift from home, affected him so much that he became emotionally detached from his family.

Vignette 2

A 30-year old man developed symptoms of sadness, feelings of hopelessness and despair. Many members of his family had been

killed right in front of him. He and his siblings managed to escape the killings. He expressed emotions of hurt regarding the whole situation. He is constantly reminded of the event and this has made him lose hope. He feels he is useless as he couldn't do anything at the time and feels he will not be able to do anything now.

Vignette 3

A female of 38 years developed symptoms of depression, insomnia and recurrent nightmares. Her home had been ransacked so they moved to a safe place for a while, but were not happy there. She felt like an alien, though they were in a safe place. So the family came back to their earlier home but it was now occupied by another family. Her father filed a case and fought in the court, and got the house back. Now that they were back in their home and she was glad, but kept feeling that she might lose the house again. She used to wake up with the same nightmares everyday.

Vignette 4

A 41-year old man developed symptoms of feelings of despair, loss of self esteem and flashbacks. He had lost his ancestral fertile land and soon after that his father was killed. The subject, though young, had to travel a lot in search of jobs as he has two younger sisters and carried the responsibility of getting them married. He lost faith in his ability; he didn't know how he could manage to get his sisters married. He had to work very hard to manage all these issues throughout his life. He had flashbacks of the past, his happy childhood and wished that it could come back. He didn't want to move on.

Vignette 5

A 32-year old woman developed feelings of sadness, nightmares and difficulty in sleeping. Her home was attacked and the family was forced to take shelter in a different place. Though the new neighbours didn't harm her and her family physically, but they didn't accept them, and treated them as outsiders. Hence she and her family came back to their home but it was completely empty. They had to start afresh. She keeps on reliving the past and gets hurt every time she thinks about it. Her nightmares are mostly of getting attacked again.

Vignette 6

A 37-year old woman became suspicious to the extent of developing paranoia, she had difficulty in emoting and was unable to sleep comfortably. She is a widow living with her son and daughter, and works as a domestic help in the neighbours' homes. She and her family were attacked and to add to her misery a neighbour of hers was shot in front of her. Being witness to this, the family fled to another place. When they lodged a complaint with the police, the police in turn looted them and burnt their house down. They faced many problems in the new place. So they left and came to their old locality only to find it in a horrible condition. Going through so many traumas has made her emotionally numb. She does not know whom to trust.

Vignette 7

A 40-year woman developed symptoms of emotional detachment, paranoia, and feelings of despair. She saw a young girl being burnt alive in front of her house. Seeing this, her family took shelter in a relative's house. She couldn't sleep at all in fear that it would happen to her or her loved ones. Her family eventually settled in a different city but she refused to go with them. She insisted on staying in the same place and since then she has never left her home.

Vignette 8

A 34-year old woman has chronic feelings of suspicion, a fear of the future, feelings of hopelessness and disturbed sleep. Her entire family had been brutally killed, and their home burned down. She managed to escape with her infant son, and found shelter. Her son gradually lost his vision and couldn't work. She is always on the edge as she feels that she will be found and attacked again. She is even scared of the future as she does not know what it holds.

Vignette 9

A 35-year old woman has developed symptoms of depression, paranoia, insomnia, and a sense of hopelessness. She was married at the age of fifteen. She lost her husband very early. But even after losing her husband, she continued to stay with her in- laws. Her father wanted her to remarry but she refused to do so. It later happened

that they were attacked and injured and their house was ransacked. They were forced to move to a new place and settle there. She longed to go back to her home but couldn't. This event affected her so much that she always lived in a state of fear that it would happen again. And because of this she never ventured out on her own.

Vignette 10

A 23-year old boy developed symptoms of paranoia, feelings of sadness, and recurring nightmares. His entire family was killed. He somehow managed to escape and took shelter in his neighbour's house. After many months of hiding he left town and stayed with his distant relatives. Though he is continuing his studies now, he is still haunted by memories of that time. He is not able to move on as he feels that it can happen to him anytime anywhere.

Vignette 11

A 35-year old man has developed feelings of guilt, sadness and hopelessness. Hundreds of people, including him, hid in a community centre to avoid getting killed. But unfortunately their hiding place was discovered and many people were brutally killed in front of him. He was hurt but he and seven others survived. He keeps wishing he had died along with his family and friends. He feels guilty for not being able to do anything and has lost interest in living.

Vignette 12

A 28-year old female has developed symptoms of depression, paranoia and she has recurrent flashbacks. She had come home from her hostel for a holiday. Her parents sent her to hide as their relatives and neighbours had been attacked and they wanted her to be safe. She hid in a neighbour's bathroom for almost three months with no contact to the outside world except a radio. When she finally came out, her entire family, relatives, her friends and neighbours had all been killed. She lost everything. She is always on edge, feeling that it is going to happen all over again.

Vignette 13

A 31-year old female developed feelings of guilt and blame and has horrible nightmares. She saw her neighbours being attacked and she knew that her house would be next. So out of fear she ran to her

backyard and climbed the tree and hid there. She heard her family members screaming. They brought her family out and burnt them alive. She witnessed the whole thing but couldn't do anything. She blames herself for this. Every night she wakes up with the screams of her family. She can't shut out the screams no matter how hard she tries.

Vignette 14

A 21-year old girl developed symptoms of depression, recurrent nightmares and feelings of despair. She hid in a school along with thousands of people in different classrooms. She knew that she would be killed and she would also have to witness her mother's and sister's killing. So she went to another room where she didn't know anyone. Everyone hiding in all the rooms including hers was brutally killed but somehow they weren't able to find her as she was hiding in a very narrow place. She even had to witness an infant being slaughtered. She is haunted by the memories every time she closes her eyes.

Vignette 15

A 45 -year old man developed feelings of sadness and betrayal, paranoia and had trouble sleeping. He was hiding in his house along with his family and friends. The men of the house fought but were exhausted and defeated. They caught him and smashed his hand and threw him to one side. He was badly hurt but he managed to hide in the bushes. He then witnessed them killing many people, even pregnant women. He also witnessed them smashing children to the walls and killing them. He feels betrayed as the people who were killing were his neighbours and colleagues. He is constantly on the lookout as he feels that his neighbours may strike again. And because of this he hasn't been able to sleep ever since.

REFERENCES

1947 Partition Archive. 2013. http://www.1947partitionarchive.org/ (accessed on 18 May 2014).

Achberger, M., M. Linden and O. Benkert. 1999. 'Psychological Distress and Psychiatric Disorders in Primary Health Care Patients in East and

West Germany 1 Year after the Fall of the Berlin Wall', *Social Psychiatry Psychiatric Epidemiology*, 34(4): 195–201.

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders* (5th edition, revised). Washington, DC: Americam Psychiatric Publishing.

Bayntun C. 2005. 'What Are We Capable Of? The Motivations of Perpetrators in South Africa during the Apartheid Era', *Medicine Conflict and Survival*, 21(1): 3–18.

Brass, Paul R. 2003. 'The Partition of India and Retributive Genocide in the Punjab 1946–47: Means, Methods and Purposes', *Journal of Genocide Research*, 5(1): 71–101.

Butalia, U. 1998. *The Other Side of Silence: Voices from the Partition of India*. London: Penguin Books.

Catani, C., N. Jacob, E. Schauer, M. Kohila and F. Neuner. 2008. 'Family Violence, War, and Natural Disasters: A Study of the Effect of Extreme Stress on Children's Mental Health in Sri Lanka', *BioMed Central Psychiatry*, 8: 33.

Cultures of Resistance. 2011. 'The Courage of Neighbors: Stories from the Rwandan Genocide'. http://www.youtube.com/watch?v=VaX7vQxNAOk (accessed on 18 May 2014).

Eisenman, D.P., L. Gelberg, H. Liu and M.F. Shapiro. 2003. 'Mental Health and Health-Related Quality of Life among Adult Latino Primary Care Patients Living in the United States with Previous Exposure to Political Violence', *Journal of American Medical Association*, 290(5): 627–34.

Jain, S. and A. Sarin. 2000. 'Some Reflections on the Development of Psychiatry in India', *National Medical Journal of India*, 13(6): 329–30.

Kamtekar, I. 1995. 'The Military Ingredient of Communal Violence in Punjab, 1947'. Paper presented at the 56th Indian History Congress, *Proceedings of the Indian History Congress*, pp.568–72, [Date], [Place].

Kecmanović, D. 2002. *Ethnic Times: Exploring Ethno Nationalism in the Former Yugoslavia*. Westport, CT: Praeger.

Khwaja, A., A. Mian and P. Bharadwaj. 2008. 'The Big March: Migratory Flows after the Partition of India', *Economic and Political Weekly*, 43(35): 39–49.

Kraemer, B., L. Wittmann, J. Jenewein and U. Schnyder. 2009. '2004 Tsunami: Long-Term Psychological Consequences for Swiss Tourists in the Area at the Time of the Disaster', *Australia and New Zealand Journal of Psychiatry*, 43(5): 420–25.

Kunitz, S.J. 2004. 'The Making and Breaking of Yugoslavia and Its Impact on Health', *American Journal of Public Health*, 94(11): 1894–1904.

Maercker, A., C.R. Brewin, R.A. Bryant, M. Cloitre and M. Van Ommeren, L.M. Jones, A. Humayan, A. Kagee, A.E. Llosa, C. Rousseau, D.J. Somasundaram, R. Souza, Y. Suzuki, I. Weissbecker, S.C. Wessely, M.B. First and G.M. Reed. 2013. 'Diagnosis and Classification of Disorders Specifically Associated with Stress: Proposals for ICD-11', *World Psychiatry*, 12(3): 198–206.

Norris, F.H. 2009. 'The Impact of Disasters and Political Violence on Mental Health in Latin America', *PTSD Research Quarterly*, 20(4): 1050–1835.

Portney, C. 2003. 'Intergenerational Transmission of Trauma: An Introduction for the Clinician', *Psychiatric Times*, 20(4): 1–3.

Rwandan Stories. 2013. 'Genocide'. http://www.rwandanstories.org/genocide.html (accessed 18 May 2014).

Sabin, M., L. Cardozo B., L. Nackerud, R. Kaiser and L.Varese. 2003. 'Factors Associated with poor Mental Health among Guatemalan Refugees Living in Mexico 20 Years after Civil Conflict', *Journal of American Medical Association*, 290(5): 635–42.

Schick, M., N. Morina, R. Klaghofer, U. Schnyder and J. Müller. 2013. 'Trauma, Mental Health, and Intergenerational Associations in Kosovar Families 11 Years after the War', *European Journal of Psychotraumatology*. http://www.ejpt.net/index.php/ejpt/article/view/21060 (accessed on 18 May 2014).

Sharon, A., I. Levav, J. Brodsky, A.A. Shemesh and R Kohn. 2009. 'Psychiatric Disorders and Other Health Dimensions among Holocaust Survivors 6 Decades Later', *British Journal of Psychiatry*, 195(4): 331–35.

Shone, Terence. 1947. Letter to Secretary of State for Commonwealth Relations, 14 October 1947 (DO 142/259). http://www.nationalarchives.gov.uk/education/topics/evaluating-partition.htm (accessed on 18 May 2014).

Varshney, A. 2001. 'Ethnic Conflict and Civil Society India and Beyond', *World Politics*, 53: 362–98.

Weine, S.M. 1999. *When History Is a Nightmare: Lives and Memoires of Ethnic Cleansing in Bosnia-Herzegovina*. Piscataway, NJ: Rutgers University Press.

World Health Organization. 2007. *The ICD-10 Classification of Mental and Behavioural Disorders* (Indian edition). Delhi: AITBS.