Collective Memories of Political Violence of Health-Care Providers in Ayacucho, Perú

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Abstract

The article presents a study about collective memories of the Internal Armed Conflict (IAC) in Peru (1980-2000) from the perspective of a group of health-care professionals providing services in the region that was most affected by political violence. A brief historical analysis of the IAC is presented. A qualitative design with 15 interviews based on Grounded Theory is used for analyzing the discourse of the participants, and accounting for collective memories of the conflict and the scares that the experience and memory of violence have left in the population and the health-care providers. The analysis focuses on four interrelated axes: (1) collective memories of conflict and its social and psychological consequences; (2) costs and benefits of narrating versus the costs of absence of narrating; (3) recovering memories as a way to overcome psychosocial trauma; and (4) direct experience, personal meanings and effects of exposure to victims' stories on the health-care providers. Results suggest a scenario of unrelenting psychosocial effects and possible re-traumatization, both in those directly affected and, in the health-care professionals treating them. In addition, central to the participants' discourse is the importance of acknowledging and claiming the right to construct the memory of the violent period as an act of justice, restoration, mental-health recovery, and strengthening of the social fabric.

Keywords

Resumen

El artículo presenta un estudio sobre las memorias colectivas del Conflicto Armado Interno (CAI) ocurrido en Perú (1980-2000), desde la perspectiva de un grupo de profesionales de la salud que prestaban servicios en la región más afectada por la violencia política. Se presenta un breve análisis histórico del CAI. Se utiliza un diseño cualitativo con 15 entrevistas basado en la Teoría Fundamentada para analizar el discurso de los participantes, y dar cuenta de las memorias colectivas del conflicto y de los temores que la experiencia y la memoria de la violencia han dejado en la población, y en los mismos proveedores de servicios de salud. El análisis se centra en cuatro ejes interrelacionados: (1) las memorias colectivas del conflicto y sus consecuencias sociales y psicológicas; (2) los costos y beneficios de relatar las experiencias frente a los costos de la ausencia del relato; (3) la recuperación de las memorias como forma de superar el trauma psicosocial; y (4) la experiencia directa, los significados personales y los efectos de la exposición a las historias de las víctimas en los proveedores de salud. Los resultados sugieren un escenario de efectos psicosociales persistentes y de posible retraumatización, tanto en los directamente afectados como en los profesionales de la salud que los tratan. Además, en el discurso de los participantes es central la importancia de reconocer y reclamar el derecho a construir la memoria del período de violencia política como un acto de justicia, restauración, recuperación de la salud mental y fortalecimiento del tejido social.

Palabras Clave

memoria colectiva, violencia política, salud mental comunitaria, restauración, Teoría Fundamentada

The Context: Political Violence in Peru and in Ayacucho

The Internal Armed Conflict (IAC) between the Peruvian State and terrorist groups- *Sendero Luminoso* (Shining Path) and *Movimiento Revolucionario Túpac Amaru* (Tupac Amaru Revolutionary Movement) – took place between 1980 and 2000. In the Peruvian republican history, it is considered the longest period of political violence, the most extensive in terms of geographic impact on the national territory, and the most significant in terms of human and economic losses (Comisión de la Verdad y Reconciliación [CVR], 2004). The Final Report of the Truth and Reconciliation Commission (TRC) established that more than 69,000 people were killed or disappeared during this conflict; among them 35% were from the poorest areas of the country, 55% were from rural areas, and over 75% were native Quechua speakers or had another native language as their mother tongue (CVR, 2004). The statistics show a pre-existing situation of exclusion and neglect of the country's poorest Andean communities, which rendered them even more vulnerable to the effects of the conflict. This explains why the Region of Ayacucho, located in the southern highlands of Peru, one of the poorest areas of the country, was the most affected in terms of loss of human lives and economic costs (CVR, 2004; Rivera & Velázquez, 2008).

After living in a violent context for over twenty years, the population of Ayacucho refer to this period and its consequences by means of different narratives, which require acknowledgement and comprehensive attention of the country's social and cultural diversity (Rivera & Velázquez, 2008). In fact, a study conducted by the TRC found that 51% of participants from the Andean central south region reported mental-health consequences of war, and that 74% also perceived such effects in their family members (CVR, 2003). These effects included both personal and a collective impact, and were associated with difficulties in facing daily-life activities (CVR, 2004).

In addition, the TRC verified that overcoming the scares that the IAC left in the population would be possible not only through the clarification of events, and justice (CVR, 2003), but also through the acknowledgement of the diverse memories of this period, especially concerning the most intensely affected populations (Asociación Nacional de Familiares de Secuestrados, Detenidos y Desaparecidos del Perú [ANFASEP], 2007). This implies that restoration proposals and policies should consider an interdisciplinary approach, and address the diverse collective narratives and representations of the conflict, in order to create the conditions for justice and recovery from psychosocial trauma caused by violence, with an eye to national reconciliation (Instituto Especializado de Salud Mental, 2004; Laplante, 2007; Programa de Apoyo a la Modernización del Sector Salud y su Implementación en una Región del Perú [AMARES] & Coordinadora Nacional de Derechos Humanos [CNDDHH], 2006; Taboada, 2008).

In light of this context, the purpose of this article is to analyze collective memories of the political violence and its consequences, from stories told by a group of professionals of health-care services in Ayacucho, Peru. Specifically, health-care providers are important actors in the attention of people affected by political violence in Peru, living with the affected population in the same communities, and in some cases for also being directly affected by the violence. Moreover, they also are responsible for detecting and attending to the psychosocial consequences of the IAC within the Government's public health programs (Laplante & Rivera, 2006). Thus, the health-care providers work with those affected by violence will be reflected in their own collective memories of the IAC.

Collective Memory as a Social Representation of the Past

Collective memory is constituted by social representations elaborated by a group about their past (Páez, Techio, Marques, & Beristain, 2007). It allows the group to organize the memories of social events and give meaning to them, serving to guide future actions (Jodelet, 1991), and is associated with the collective identity of group members as a mechanism of group cohesion (Licata, Klein, Gély, Zubieta, & Alarcón-Henríquez, 2011; Lyons, 1996; Páez, Bobowik, Guissmé, Liu, & Licata, 2016). Furthermore, collective memory influences the emotional state of the group's members as well as their values and norms (Páez et al., 2016).

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Collective memory builds upon social relations, through the processes and practices that define them (Halbwachs, 1950/1992; Reátegui, 2010). Members of a collectivity evoke certain past events based upon a consensus they have reached by means of shared and legitimated social codes at a specific time in history (Dobles, 2009; Halbwachs 1950/1992; Jelin, 2002; Ricoeur, 1999). Furthermore, the evocation of history depends on the political aims and interests of the involved actors (Figueiredo, Martinovic, Rees, & Licata, 2018).

Thus, to understand the construction process of collective memories, it is necessary to examine the social practices and the power systems that reproduce and sustain the contents of the memories, and to establish hierarchies among them, thereby creating a distinction between valid discourses and those that do not have a valid relation to the official truth (Foucault, 1992). Frequently in relation to the same event, one finds differences between official and popular recollections, especially when official memory tends to be that of dominant groups in the society (Páez et al., 2016).

Collective memories about the past are reconstructed from the challenges that frame the social identity posed by the groups (Swindler & Arditi, 1994), as well as providing contents that in turn attribute meaning to this social identity (Figueiredo et al., 2018). Thus, the existence of different memories of victims of the same violent acts, of their relatives, and of the victimizers are also motivated by the preservation of a particular social identity (Reátegui, 2010). The way in which each social group interprets the violent acts in its history conditions the memory-of these facts, in accordance with the group's own projects and future expectations, thus favoring narratives of the past that are entwined with specific meanings about the present (Barrantes & Peña, 2006).

Memories of Political Violence and Psychosocial Trauma

Political violence consists in the intentional use of force against a group or community by organized collectives that pursue certain political objectives, and whose actions result in death, or physical or psychological harm to those affected (Ubillos, Beristain, Garaigordobil, & Halperin, 2011). It consists in a sequence of threats and aggressive acts that rarely circumscribe to a single event (de la Corte, Sabucedo, & de Miguel, 2006), and comprises all forms of war, violent conflicts, terrorism and State violence against antagonist groups (World Health Organization [OMS/WHO], 2002).

In addition, being exposed to situations of political violence usually leaves different degrees of traumas in individuals and communities. The intensity of emotional suffering and its persistence over time impacts victims' health, while it is common for victims to externalize their worries and anxieties, as well as turning their psychological problems into common physical ailments or illnesses (Larisgoitia et al., 2009). The experience of violent acts in the past results in violent collective dynamics, which have consequences for individual and community mental health (AMARES & CNDDHH, 2006; CVR, 2004).

In Peru, violence has left wounds that prevent people from establishing interpersonal bonds of trust and solidarity, making it difficult for them to keep social support networks that allow them to overcome the effects of conflict, and in general, to face and transform the extreme poverty and marginalization in which they still live (CVR, 2004; Laplante, 2007). People directly exposed to violence may have persistent feelings of sadness, irritability and fear, psychological disorders and eating disorders, as well as a desire to die, difficulties studying and working, physical symptoms like headaches, panic attacks, muscular and stomach aches, fainting, and body weakness (CVR, 2003; Pedersen, 2009).

The evidence in the Peruvian case indicates that, at the collective level, family and community are disintegrated, coexistence is altered, and social groups are stigmatized (CVR, 2004). Mental health has also been affected by displacement and by the destruction of public and community infrastructure (Laplante, 2007). Settlements of families that had to leave their homes because of war have high rates of domestic violence and mistreatment, alcoholism, suicide attempts, delinquency and gang participation (Gobierno Regional de Ayacucho, 2007).

Therefore, understanding trauma originated by acts of political violence requires going beyond the individual level of analysis, given that it not only involves personal harm, but also the suffering of the collectives and society as a whole. In this sense, it is appropriate to consider it as psychosocial trauma (Martín-Baró, 2003), which includes the destruction of belief systems and cultural meanings, that annihilate or deeply limit the possibility of future generations to recover crucial aspects of their social and cultural life (Comas-Díaz, Lykes, & Alarcón, 1998; CVR, 2004). Psychosocial trauma imprints particular nuances to the process whereby the memory of past events gets constructed. On the one hand, there are the survivors who feel the need to tell their stories and, on the other hand, there are others that defend their right

to silence in order to go back to "normal" life and leave behind traumatic events, or because they are afraid of hurting loved ones with their stories during the conflict (Espinosa et al., 2017; Jelin, 2002; Páez & Basabe, 1993).

Even though silence can have an evasive nature, and can show an attempt to forget the pain, there are other types of silence that are imposed due to fear of the consequences of speaking (de Rivera, 1992; Ricoeur, 1999). This last process is what is understood as "collective or social forgetting" as a result of an impositions from who detents power (Juárez, Arciga, & Mendoza, 2012). According to this, the seeking to express and communicate memories about violence is a challenge to groups in power or to their commands. In these cases, remembering is also a way to keep the group's identity, a sense of continuity and the possibility of learning about ethics, about the nature of the present and about how to build the future (Juárez et al., 2012).

At a collective level, the balance between remembering and forgetting is connected with the existence and institutionalization of collective symbols that recognize the existence of events that occurred during the violence and which serve to remember the past (Páez & Basabe, 1993). The existence and promotion of these social symbols and rituals imply a positive attitude towards the memory that promotes the identification and recognition of events at the collective level. This is even more relevant in contexts where there is a tension between individual grieving processes and a society that wants to forget (Espinosa et al., 2017; Lira & Castillo, 1993).

It has been established that repression of trauma is associated both with individual and collective discomfort (Pennebaker, 1993) and talking about traumatic events with others is associated with more positive views about the emotional context of one´s country (Páez, Asún, Igartua, González, García, & Ibarbia, 1993). In addition, it is understood that collective memory is a particularly relevant concern in conflict situations (Páez et al., 2016), since it is possible to identify complimenting recollections distributed among the members of the same group with reference to the same event (Figueiredo et al., 2018).

Collective memories of violence, besides helping to build a particular narrative about political violent events, help to determine the limits of the decisions and policies that will be implemented to deal with violence. The imposition of one memory of conflict events is a way of ignoring and neglecting the need to recognize and value the identity of those cultures who are not necessarily represented in that single and dominant memory of violent events (Licata et al., 2011).

In this context, and in keeping with its discursive nature, memory about political violence is constructed in an antagonistic relation between the different actors involved in the violent acts (Barrantes & Peña, 2006; Reátegui, 2010). Failure to recognize the various collective memories can lead to tensions, distrust and hostility between the groups (Bar-Tal, 2000). At the same time this revictimization might obstruct the process of reconciliation after the conflict (Licata et al., 2011).

It is important to consider that narratives and memories deal with multiple aspects of a social experience, and thus, it is important to understand that a violent process involves considering multiple dimensions, such as its origins, responsibilities, events, actors and causes (Reátegui, 2010). Even though traumatic facts may be silenced or denied for political reasons, due to the existence of social conditions that make it impossible to acknowledge them, nonetheless, contrary to common assumptions, silence with relation to violent acts does not replace memory; in fact, there is an interaction between them at all times (Jelin, 2002).

Given that repression, oppression and violence deeply impair the possibility to make sense of events through objective accounts of them, the first step towards overcoming psychological harm is the recovery of painful memories and experiences. Therefore, the need arises for political and social acknowledgement of the narrative of those affected by violent acts (Dobles, 2009).

An important aspect of initiatives to overcome processes of political violence and their effects, like transitional justice processes such as Truth Commissions, is that they help construct a collective memory that integrates and acknowledges the real suffering of the conflicting groups (Beristaín, Páez, Rimé, & Kanyangara, 2010; Espinosa et al., 2017). Recognizing the diversity of memories of different groups improves intergroup attitudes. However, for this to happen there must be preexisting levels of intergroup and institutional trust (Alarcón-Henríquez et al., 2010; Mathias et al., 2020).

Establishing relations of cooperation, non-hostility, and reinforcement of trust among groups is a precondition for building inclusive collective memories, therefore the first phase in overcoming conflict is instrumental negotiation and cooperation. This may be achieved by regular contacts among the previously confronting groups, so that they

may modify basic beliefs about the social world, such as the benevolent and fair character of the world, and values affected by violence (Arnoso et al., 2011; Larisgoitia et al., 2009). The second, a more advanced phase is socio-emotional reconciliation, which implies acknowledging past mistakes and others' suffering, as well as legitimizing their memory and stories about what happened. This phase relies on apologies by victimizers, and acceptance of the apologies by the victims, and it helps to integrate the conflicting groups into a single collectivity (Licata et al., 2011; Páez, Valencia, Etxebarria, Bilbao, & Zubieta, 2011).

Therefore, it is possible to argue in favor of collecting and revealing different existing memories about the political violence in Peru, because this would be helpful in the national reconciliation process, by providing conditions that allow and promote integration of the different meanings and narratives about violence, contributing to recovery and healing of the psychosocial trauma generated by these events. In view of this, as previously mentioned, the objective of this study is to analyze the collective memories of political violence and consequences among a group of health-care providers in Ayacucho, Peru.

Method

Participants

Participants were four men and 11 women serving at health-care centers located in impoverished urban zones in the city of Huamanga, Region of Ayacucho, between the ages 31 and 48 with 3 to 26 years of service in the public health system.

Distribution of their professions were as follows: six nurses, three physicians, three psychologists, one social worker, one obstetrician, and one medical technician, assigned to caring for victims of political violence.

Most of them were born in districts of Ayacucho or close-by provinces, and had direct contact with political violence, either as witnesses of violent events or as relatives or close friends of people who was killed, disappeared or suffered other ways of human rights violations. All of them had been trained in community mental health as a policy of the National Department of Health for these areas.

A sampling design was developed, whereby the final list of participants was defined through systematic interview analysis, which involved continuous generation of hypotheses about the relations between the constructs of interest in the study. As new hypotheses emerged and so the need for empirical contrast, new participants were contacted (Strauss & Corbin, 2002). This process was repeated until achieving theoretically defined saturation. Sampling was based upon Kleining (1982) ideas according to which every time a factor was presumed to have influence upon the results, that factor would be varied in order to continue sampling. In our specific case, those variation factors for sampling were initially given by the features of the health-care providers as: their profession, time of service in that area, place of birth (urban or rural area) and sex. When it was considered that one of those factors or other emerging factors might affect a different set of beliefs and evaluations about the people they serve, more variability in the sample was pursued according to that factor (that is maximum variation) so as to include all possible variations.

Data Collection

Individual in-depth interviews were conducted, in which general topics were presented, through a list of questions, for the interviewees to express their views. This work drew upon Grounded Theory, according to which the interviews are based on certain thematic axis (see Table 1) that allow relevant topics and questions to emerge during the data-collection technique (Strauss & Corbin, 2002). In this kind of interview, it is the interviewee who sets the rhythm of the conversation, by raising the topics he or she deems relevant, elaborating on them, and building a coherent and experiential discourse that is empirically supported (Mejía, 2000).

Table 1

Structure of the Interview Protocol: Thematic Axis and Emerging Questions

Structure of the interview protocol	
Thematic axis	**Emerging Questions**
Axe 1. Collective memories of conflict and its social and psychological consequences.	What are the most significant events the people remember? Why? How are those events explained? What are the most important consequences/effects of violence? How has it impacted the relationships among residents? Have changes taken place in the customs, beliefs and habits of the population?
Axe 2. Costs and benefits of narrating versus the costs of absence of narrating.	How do those affected deal with the effects of IAC? Do the people talk about the events? In what circumstances do they do so/not do so? What benefits/costs derive from providing testimony of IAC? What are the effects of listening to the stories about violence on the society at large?
Axe 3. Recovering memories as a way to overcome psychosocial trauma.	What is the relationship between the processes by which memory of violence is constructed and the recovery of the affected population?
Axe 4. Direct experience, personal meanings and effects of exposure to victims' stories on health-care providers.	What are the most significant events that you remember and why? How do you feel about (how do you react to) the stories told by victims and your contact with them?

The interviewing protocol was administered in Spanish as that is the native language of the majority of the participants, even though some speak both Spanish and Quechua.

Procedure

Interviews were conducted between the end of 2007 and the beginning of 2008, five years after the delivery of the Final Report of the Truth and Reconciliation Commission, and seven years after the end of the period of the greatest and most intense territorial violence.

Participants were previously selected to attend an internationally-funded training program lasting about a year, in which they were instructed on how to treat victims of political violence from the theoretical and practical perspective of community mental health. Part of the contents presented in this program were related to collective memory, Human Rights and recovery from trauma. At the same time, the participants conducted practical activities of social and psychological diagnosis and community interventions with populations that were victims of political violence (AMARES & CNDDHH, 2006).

Regional authorities of the Peruvian Department of Health allowed the research team to have access to the list of professionals that participated in the training course mentioned above. Thus, to avoid the possible influence of power relations between the researchers and the interviewees, the interview structure was always open, and interviews were held in places where the participants felt comfortable and could express their opinions freely; only with people who later agreed to participate voluntarily (see Mellor, Bretherton, & Firth, 2007). In addition, their preferred availability and meeting places were respected when contacting and interviewing them. Considering the guidelines for theoretical sampling, the order in which the health centers were visited and the interviews carried out was determined by the results of an initial contact with potential interviewees, which helped identify the required elements and characteristics of the participants, considering that the objective was to obtain as much diversity and depth in their answers as possible. Therefore, it was necessary to travel from one area to another in order to reach theoretical saturation for emerging categories, according to the logic of qualitative research (Strauss & Corbin, 2002).

The method of analysis used was the one proposed by Grounded Theory (see Strauss & Corbin, 2002), which consists of a sequence of procedures to initially identify the emerging categories in the text and their specific characteristics

expressed in relation to the object of study, thus giving rise to central concepts or ideas. Finally, linking the main concepts made it possible to obtain conceptual networks and a greater integrated theoretical framework, thus shaping an emerging theory about the object of study (Strauss & Corbin, 2002).

For data analysis a senior investigator, specialist in qualitative research, followed the grounded theory method of analysis with the support of the qualitative data analysis program Atlas Ti 5.0. Moreover, the data analysis process was audited by another senior investigator in order to guarantee the quality of the process. Analysis consisted in a sequence of procedures that allowed firstly, to identify and analyze emerging categories (open codification) and secondly, to perform a relational analysis in two stages (axial codification and selective codification) in order to achieve conceptual networks around key concepts (Strauss & Corbin, 2002).

Open codification: Initially a descriptive analysis was conducted in order to systematically and objectively describe the content of the communication during the interviews (Scribano, 2000). This allowed for identifying the categories that would be later organized in concepts with specific properties and dimensions (Stone, 1966, as cited in Scribano, 2000).

Axial codification: Categories and sub categories were associated in order to explain and analyze the study data (Strauss & Corbin, 2002). Data was connected according to its dimensions and properties around a central axis, which is a category. Therefore, the data that was divided during the open communication phase was regrouped. It is important to mention that this procedure did not require that the open coding analysis be concluded, although it did require that some of the identified categories be available (Strauss & Corbin, 2002).

Selective codification: Through this process, the main concepts were articulated in a new theoretical scheme, which becomes an emerging theory about the objects studied, based on the narratives of the interviewees (Strauss & Corbin, 2002). This theoretical scheme pointed to a group of categories or dimensions that organized the contents of the narratives which structure the presentation of results: (1) collective memories of conflict and its social and psychological consequences; (2) costs and benefits of narrative versus costs of absence of narrative; (3) recovering memories as a way to overcome psychosocial trauma; and (4) direct experience, personal meanings and effects of exposure to victims' stories on health-care providers.

Relevant ethical considerations included: selecting health-care personnel that had already been trained by diverse actors in civilian society and the State, and that had been able to deal with their own experiences with violence; and having a network of mental-health referrals, in case the interviewees needed assistance. In addition, the participants were informed about the objectives of the study, they were asked permission to record the interviews, and they were ensured anonymity of their opinions throughout the study. Specifically, during interview and data analysis processes, names of participants were neither used or requested. To describe the sample collectively, just some socio-demographics characteristics were registered and used.

Results

The analysis of the interviews reveals the discourses of the health-care providers about memories related to the IAC in Peru. In this section, health-care professionals' discourses on topics that emerged from grounded theory analysis are presented in four axes: (1) collective memories of conflict and its social and psychological consequences; (2) costs and benefits of narrative versus costs of absence of narrative; (3) recovering memories as a way to overcome psychosocial trauma; and (4) direct experience, personal meanings and effects of exposure to victims' stories on health-care providers.

Collective Memories of Conflict and its Social and Psychological Consequences

Narratives of health-care providers about the period of IAC are strongly linked to their social and professional practices and their present-day ways of signifying and guiding their relations with the immediate social environment. Interpreting violent acts and their effects gives meaning to their professional work. These representations are for them means to explain patients' characteristics and reactions, which they consider as negative consequences of violence in the mental health of the population affected.

They talk about everything, everything that happened; they cry as if it had happened yesterday. Their pain is something... that will never heal. It isn´t true when they say "in a few years one forgets, it´s over, it´s over". That´s a lie. Female social worker, age 46

Children have behavior problems; they´re very aggressive, both boys and girls. They have learning problems; some of them are very anxious. Another problem is that they´re very shy; and then there are the strictly neurological problems, which also have to do with violence. Female psychologist, age 46

Many participants reported having closely experienced political violence. Those experiences led them to have vivid memories that still have an impact in their present lives and in their social interactions. Thus, they share with their patients the everyday feelings of fear, pessimism and uncertainty on a daily basis, feelings that constantly bring back their memories of pain.

In those days you wouldn´t know who was who: who belonged to Path (Shining Path), who was an informer, or who was in the military. So, who could you trust? In those days, you could get killed for revenge, even if you didn´t belong to Path. That´s how we've lost our confidence. We see many things even here, and we always take a few precautions. Female obstetrician, age 38

I also experienced political violence as a student. It all started in the 80s, when I was at school...I have gone through it. I am still going through it, because of the havoc created by violence. My friends and neighbors, the population we know have suffered. Female nurse, age 40

For health-care providers, those affected by violence were represented as total and permanent victims, with limited capacity to assume control over their lives and affecting their capabilities to trust other people and the institutions. This enabled them to explain the apparent inaction and passivity of those affected in the face of the violence they had suffered in the past, and also in the face of the poverty and exclusion in which they were living, all of which was exacerbated by lack of justice and restoration.

Post-traumatic stress abounds, even in ourselves, because as caregivers, we have lived that (the violence). Sometimes they are fearful, anxious, very mistrustful. Even we many times can´t talk about what happened because we're still afraid, on account of what we've been through. Female nurse, age 40

People have changed too much. They used to be more open to visitors. We used to be more affectionate towards them, we welcomed them fondly, but now we're on the defensive. Practically, we aren´t as trustful as we used to. Female nurse, age 52

It is the latter that the interviewees associated with greater effects, resulting in the breakdown of the social dynamics that preceded the violence. According to the narratives, it would seem that the most visible symptoms of this trauma are the loss of aspects of cultural life, and of other identity referents, caused by displacement and flight.

Yes, (the communities) have been affected...Some communities continue holding their festivities, but the displaced communities that are here in the city no longer celebrate their festivities; they've lost their customs. Female nurse, age 37

They do nothing, nothing (collectively)...they're no longer interested in their patron saint...they don´t have any. Neither do they have an anniversary of their human settlement, they don´t have it. Female physician, age 37

Thus, the effects of political violence, from the narratives of the interviewees, are evident both at the interpersonal level, in terms of distrust and passivity, and at a collective level, in the cultural loss of community traditions, producing a negative impact on social cohesion.

...violence proper, in its limit, has definitely disrupted the whole community; it no longer exists, it is falling apart. Male physician, age 35

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Costs and Benefits of Narrating Versus Costs of Absence of Narrating

In the representation of health-care providers, there was a permanent memory of violence, although the interviewees noted that this was not always communicable. In some cases, people are not willing to speak about the past. However, the attempt to forget was not always successful or favorable.

> *Most people in the population won´t speak openly about it; what´s more, they´d rather not talk about it at all. But they do present quite a lot of depression and headaches; they generally externalize.* Female physician, age 32

On the other hand, there were also those able and willing to tell the stories:

> *When I visit them, they seem eager to talk to me; they want to tell me what they´ve gone through, and say: please, care for us.* Female nurse, age 45

> *They want to leave behind that dark period, but they also claim the remains of their loved ones, and ask that a memorial be built, so that the past events become known. Symbolic restoration.* Male psychologist, age 38

Thus, the need and interest to communicate the memory of past experiences seem to go hand in hand with a demand of support and restoration that would help the victims overcome the scars of conflict.

Recovering Memories as a Way to Overcome Psychosocial Trauma

The visibility and acknowledgement of collective memories and diverse narratives about the conflict and its effects were seen by the interviewees as an essential step towards overcoming psychosocial trauma. Besides, it was considered that dissemination of such experiences would protect, to a certain extent, the younger generations, should violence return.

> *Sometimes I still get together with the kids in my street, because I think that sooner or later the problem may come back, and they must be prepared, they must know what happened.* Female social worker, age 46

> *For example, we have the memory museum and every time the kids go by it, they say: "why have they drawn a little head on one side and a foot over there? What is this?" They don´t know that is a scene of what happened, because that was how it really happened to the dead people!* Female social worker, age 46

Therefore, for caregivers the testimony about violence was a fundamental element in the recovery of mental health of the population affected, as well as a way of pursuing justice and compensating the victims.

> *When talking about exhumation, some people say "this wound has already been closed, why open it again?" It´s just that those affected need us, and it is healing for them to share all that pain, that feeling! We talk and they feel better and thank us.* Female social worker, age 46

Interviewees held that the State has a large responsibility which was not fully assumed, probably because they still do not fully understand the experiences lived by victims. Participants also considered that the patterns of exclusion and discrimination marking the dynamics between the capital and the country's provinces might be at the heart of this neglect on the part of the State and society in general:

> *Social development is lagging behind. I´d say it is in the pre-historic age. When I go to Lima, when I go to the shopping centers, and then I come back to Accomarca, Carhuanca, Vischongo, Santillana, Huamanguilla, I see a different reality. I´d love all Peruvians to see this reality for themselves, to notice the contrast with Lima, for example!* Male psychologist, age 38

> *The educational standard in rural zones is dreadful, and so is health care. We´re talking about peasants, most of whom haven´t finished primary school. They can´t read or write. So far there has*

been total neglect there, because the State hasn´t reached the communities. Or if it has, it has done so in a bad way. There is evidence of veiled racism over there. Indicators clearly state it. Male physician, age 35

Furthermore, for interviewees, visibility and appreciation of the victims' narratives, as well as acknowledgement of their current situation, as strategies for overcoming the psychosocial trauma, would require addressing the effects on individuals and on social practices and cultural traditions.

In Accomarca they´re still crying, crying…How great it would be for them to bury their loved ones! How great it would be if the government recognized what has happened there! The people want to leave this period behind, but also want the remains of their loved ones, and a memorial right there, in their community. Male psychologist, age 38

One of the greatest consequences we can see is the lack of communication in the social network. The social network has broken down. Many families accused innocent people out of despair, to the detriment of the social fabric. There´s a high degree of resentment and hatred among the families of a single community. Male psychologist, age 38

For participants, initiatives to maintain the cultural practices were central elements for successful psychosocial recovery processes. Therefore, it would be necessary not only to remember the violence and the pain, but also to recover the social dynamics and strengthen the social bonds and support networks, which contribute to creating new identities and community meanings.

They keep their culture, their traditions. For example, they celebrate carnival festivities in their neighborhoods. They still hold the minca[1], the ayni[2] , they collaborate. When someone dies, everyone goes to the funeral. They take flowers, a candle, they stay at the service, that is, there is still that sense of unity, support, collaboration. Female social worker, age 46

They do help each other; they´ve learnt to help each other. I have even seen old men who have suffered the political violence, and their neighbors bring them to the health-care facilities. Likewise, neighbors sometimes help each other in times of need. Male medical technologist, age 31.

Direct Experience, Personal Meanings and Effects of Exposure to Victims' Stories on Health-Care Providers

Interviewees indicated that the narrative of violent events created in themselves a feeling of closeness and empathy with the affected and displaced communities. In essence, a concomitant memory was constructed, which placed the professionals in the role of impotent and passive victims in a situation that got out of hand. Therefore, an element of identification placed those who were supposed to heal in the position of those affected; more so considering the direct experience with the violence lived by some of the interviewees.

How much suffering those women have! They´ve lost their children, their husbands, and so far, we haven´t been able to ease their pain. If we, as part of the State, gave them the remains or the clothing, whatever was left of the deceased relatives, I am sure their wounds would heal and they would be able to move on. Male psychologist, age 38

As discussed above, health-care personnel showed a sense of commitment by responding to the victims' narratives, reporting the cases to the authorities, and taking concrete action in their capacity as public servants. In many cases, this commitment echoes their needs of self-care and attention provoked by the participants' personal history with the political violence.

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1) Collective work in activities that benefit the whole community.

2) Reciprocal work between the members of a community.

> *When I look at the population, and when they come to me, I also regard myself as part of them. As if*
> *I am ill myself, how will I be able to care for them? I need treatment in the first place...we´re all ill.*
> Female nurse, age 48

In this context, by problematizing their own involvement in treating the mental health and psychosocial trauma of the population, the participants identified in the affected population the same conditions and consequences that were not treated in themselves.

> *And now I can say that the consequence is that we´re distressed, desperate. We deal with the patients*
> *in ways that aren´t viable or adequate. There´s no assertive communication, our self-esteem is not high,*
> *mutual support and solidarity have been lost.* Female social worker, age 46

In this respect, the participants expressed self-criticism and feelings of impotence when contrasting the population's needs and their real capacity to provide care, as professionals and employees of the State. Therefore, they questioned the State's prioritization of this aspect, as well as how well-suited their own institutions were to provide treatment for mental-health recovery in a relevant and effective way.

> *Sometimes I feel impotent because I can't do this alone. I am willing to do, to work and everything, but*
> *I feel impotent.* Female nurse, age 52

> *The matter of budget and resources is a limiting factor (...) I believe it is a question of governmental*
> *jurisdiction. Something must be done because the budget isn´t enough; it is a matter of prioritizing and*
> *assigning human resources, I think.* Female physician, age 37

Discussion

The present study analyzed the collective memories of the past among health providers that work in the most affected areas by the IAC with respect to the period of political violence and the processes of post-conflict reconstruction and repair.

Through interviews with these health-care workers the study found that there still remains a vivid memory of the violent events that occurred during the IAC and this appears both in their narratives about what happened and in references to current communities' situations that are attributed to the consequences of being subjected to political violence. These results are consistent with the theory of social representations, which proposes that social representations of the past guide interpretations of the past, present and future situations (Jodelet, 1991).

Consistently, participants refer to a negative effect in interpersonal relations where emotions of mistrust and fear between the people they attend predominate. In that sense, one could identify a prevailing negative socio-emotional climate expressed in emotions of mistrust, suspicion, and alert, as has been found in previous studies (CVR, 2004; de Rivera, 1992). These negative attitudes and emotions are the result of the violent events of the IAC, and not having been processed in adequate ways, affect the current interpersonal and collective interactions within society.

Memories of conflict shared by the interviewees illustrate what Martín-Baró (1988, 2003) describes as a scenario of psychosocial trauma, in which it is possible to identify the effects of violence in individuals as well as in the group. These testimonies were consistent with the evidence found in other studies about the mental health of populations exposed to collective violence, where psychopathological disorders and difficulties in interpersonal relations and in social and community networks prevail (CVR, 2004; Pérez-Sales, 2004; Scherg, 2003). On the other hand, references to their own experience with political violence episodes are relevant to the extent that it is from this identification with the victims, that the health care personnel interact with their patients. This particular situation would imply for health workers a greater demand for personal, emotional, cognitive and behavioral self-reliance, which generate conditions for the development of greater work stress and exhaustion (Ansoleaga & Toro, 2014; Bilbao, Martínez-Zelaya, Pavez, & Morales, 2018). It is also evident in the narratives, intertwining perceptions of conditions of poverty and exclusion of the population affected by the political violence. Within this scenario, health-providers evaluate the possibilities of recovery as very difficult and complex, or at least they are not confident about the impact of this process among those

affected. This is best understood in a social context in which power relations between health-care professionals and the population they serve implies a hierarchical relationship which is culturally assumed as natural (Rivera, 2003). As the literature indicates, it is current cultural codes and understandings (as those describe above) that play an important role in the interpretation of past events and expectations for the future (Dobles, 2009; Halbwachs 1950/1992; Jelin, 2002; Ricoeur, 1999). To this is added the effect of the traumatizing experiences of the health personnel, as noted above. These narratives suggest that the environments where the health-care participants worked were spaces that promoted story-telling about violence, and contact with the victims' emotions of pain and fear. This was associated with the health-care professionals' acknowledgement of their own personal disconforts and consequences, also reported in other studies on the relationship between caregivers in zones affected by violence and the population treated in health-care facilities in Peru (AMARES & CNDDHH, 2003; Rivera, 2003). These health providers and the people they serve, as Jelin (2002) mentions, find in their narratives the condition to give meaning to their own survival and their search for justice and truth, even despite the pain involved in recalling what happened.

The possibility of recalling the past through their own memory, would favor the health-care professionals in having empathy for their patients and the general population, as victims of the same violence. This empathic reaction is natural and is to be expected in light of the suffering of others, recognized as similar to oneself (Huici, González-Castro, Gómez, Morales, & Bustillos, 2011), especially in the case of people whose profession is precisely to care for patients' mental and physical well-being. In this respect, evidence suggests that, for those affected, finding someone willing to listen to them and embrace their pain could relieve the incomplete mourning, which is usually diagnosed as part of the disorders caused by traumatic events (Páez, Fernández, & Beristain, 2001). Thus, under certain circumstances, acknowledging the meanings and narratives of those affected by violence is fundamental in the recuperation process (Alarcón-Henríquez et al., 2010; Arévalo, 2010).

Nevertheless, being constantly exposed to the emotional manifestations of people who have suffered such traumas may create in the listeners, in this case the health-care personnel, emotional exhaustion (Jenkins & Baird, 2002). There is evidence that identification with the victims, as well as empathic engagement and emotional closeness to them, could in the long-run lead to negative health effects and burnout, resulting in vicarious traumatization (Jenkins & Baird, 2002), and facilitating the appearance of compassion fatigue disorder (Rossi et al., 2012). This is the emotional toll involved in caring for others (Figley as cited in Jenkins & Baird, 2002).

Although, in the case of our participants, empathic engagement could positively affect job satisfaction, it could also blur the boundaries of the caregiver role, which would make them more vulnerable to the negative effects of trauma exposure (Jenkins & Baird, 2002; Sabin-Farrell & Turpin, 2003; Sabo, 2006), considering the psychological and material limitations of assistance activities, among them, the lack of self-care practices and attention to their own mental health (Defensoría del Pueblo, 2006; Rivera & Velázquez, 2008). The weaknesses perceived by the participants are also reflected in the diverse institutional diagnosis made after the IAC. These reports also deal with problems in terms of logistics, and intercultural relations between the caregivers and the population from the zones affected by violence (AMARES, 2003; Rivera, 2003).

The perceptions and demands from participants with respect to difficulties for psychosocial recovering of the affected population, are consistent with theoretical proposals about the conditions that must be met in restoration and reconciliation processes, which give prominence to recovery of and claims to the right of the diverse memories of past events (Licata et al., 2011; Páez et al., 2011). Conceptually it is understood that post-conflict recovery processes require both a recognition of the memories of the victims and an improvement in their living conditions and well-being, specifically in those aspects and ways in which the victims claim for reparation (Beristaín et al., 2010; Hamber, 2007; Larisgoitia et al., 2009). On the contrary, the lack of acknowledgement and the little value placed on the victims' demands for attention and justice is usually seen as an unfulfilled pedge and-an injustice contributing to perpetuating the violence, and experienced as a specific impediment to psychosocial restoration. This is confirmed by the evidence gathered in diverse transitional justice experiences (Beristaín et al., 2010; Hamber, 2007; Larisgoitia et al., 2009).

As a limitation of the study, it is important to consider the period of the collection of the data, which was a few years after the delivery of the TRC final report and at the beginning of the process of reparation to victims of violence. As noted, health personnel were considered a fundamental part of post-conflict processes. However, towards the beginning of the post TRC process they had still received little training, especially in relation to their own histories

of experiencing violence. The implementation of new strategies for strengthening the capacities of health personnel is likely to incorporate these experiences into their collective elaboration of the process, new elements that might generate changes in the narratives of current healthcare providers.

Another limitation could be that at the time when the research team was doing its fieldwork, they did not have a greater familiarization with the professional activity of the interviewees in their interaction with the people they serve in their health facilities. Future studies should combine observation procedures and a closer attention to health personnel activities, so as to have more elements to understand the particular emphasis given to certain topics of their narratives.

Conclusions

Our study aimed at providing a contribution to better understand the process of social reconstruction and reconciliation in post-conflict societies, from the Peruvian experience. An important contribution of our study is that it provides useful insights into the complex psychosocial dynamics of the experience of healthcare providers assisting fellow community victims of political violence.

The study generated empirical evidence regarding the importance of the diversity of memories and narratives about the political violence, and has shown the way in which those different versions of the conflict have diverse set of impacts on peoples' lives, valuing their experiences, making decisions and influencing the way they are now relating to each other in their present lives.

The study reaffirms the need and importance of disclosing the memories of the victims in order to promote the perception that they are being valued by a society which has largely ignored them. This also is pointed out as a means for promoting mental health and healing psychosocial trauma. At the same time making victims' memories visible is a way of politically recognizing and addressing their suffering which is key to social and national reconciliation.

Finally, given the nature of the study and its specific scope, the authors view it as a first step toward a dialogue that posits greater interest in this topic and that in turn generates more knowledge of the complex problem of national reconciliation in the country. A pending task is to conduct more research with different and diverse types of participants, delving into some topics that have been further suggested. At the same time, we intend to contrast this information with other information gathered in different contexts and social groups, as well as to be able to advance in future studies using mixed quantitative and qualitative approaches.

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