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Hidden Injuries of Displacement: Greek Cypriot Refugees and non-refugees compared.[i]

Peter Loizos

Crisis States Programme/DESTIN/Department of Anthropology, LSE,
and School of Social Sciences, Intercollege, Nicosia.
P.loizos@lse.ac.uk

Assisted by Constantinos Constantinou, Intercollege, Nicosia.

The Issues

This paper explores several issues, building on ethnographic research, qualitative and quantitative, over a period of 35 years, with three major research times – 1968, 1975, 2000-2003, and a modest survey in 2004. The broad aim is to suggest how the Greek Cypriots from a village in W. Cyprus [Argaki] coped with displacement and near-destitution from August 1974, which became "protracted exile" [Zetter 1992, 1998] until today. During earlier field research people of all ages were studied, and a lengthy survey of 200 married male householders in 1969, [landholdings,basic demographics, livelihoods] . A shorter, smaller survey was conducted in 1975, when the villagers had been refugees for 8 months, and in-depth interviews with both men and women were carried out in both periods. In 2004 another short, simple survey [hereafter, the 1930 Cohort Survey,] was carried out. Questions were asked of men and women born in Argaki between 1930 and 1940, and a parallel survey conducted with the same age group in the nearest non-refugee village to Argaki, Astromeritis by name. This "control" study was done by Constantinos Constantinou. The concerns were livelihood and health of the respondents, people aged 64 to 74. And questions about the ages, education, and occupation of their children, typically aged 35 to 50 today.

This concern with an 11 year age cohort has a particular rationale because health issues [e.g. death, cardio-vascular illness] are age-effected. But in order to get to the health data, it is necessary to "cascade" through causally prior issues of household economics, and the social connectedness of the pre-1974 Argaki villagers.

An important methods point: Astromeritis, the "control" non-refugee village, had not been studied by me at all, and has been studied by Constantinou, in 2003 and 2004, using survey methods only. We are both well aware that there is a lot we would like to know about Astromeritis, which we can approach by proxy methods only. Perhaps in 2005 we shall be able to understand historical Astromeritis in more depth.

A second caveat: the 1930 Cohort Survey which is the basis for the health discussion was very deliberately a short, simple and highly limited instrument, originally designed for telephone interviewing. It had three concerns – a description of livelihood activities over the

working lifetime; questions about the educational and occupational statuses of the respondents' adult children, and questions about respondents' health We were warned that in Cyprus, no-one would stay on the telephone answering questions for more than eight minutes. In the event most of the interviewing was done face-to-face, but we have not collected – for example- comparative household income data.

This article will approach these issues under four thematic headings – economic impacts, social impacts, narrowly physical health impacts, our key interest, and lastly, broader emotional issues. I propose a sequence of functional priority in refugee survival issues: Paraphrasing Bertolt Brecht, first people must eat, then they can have morality. First, livelihood economics, food, shelter, incomes. Secondly, social networks, social capital, community or its disruption. Thirdly, illness and wellness. Lastly, transcendental expressiveness.

Theme One: Managing the Economic Crisis.

Shorthand: GCs = Greek Cypriots, TCs = Turkish Cypriots.

The political conflicts in newly independent Cyprus between 1963 to 1974 violently re-arranged the islands' Greek Cypriot and Turkish Cypriot populations almost totally. Where once Turkish Cypriots could be found in all the main towns of the islands, in all-Turkish villages and in many Greek-majority villages, and some Greek Cypriots in Turkish-majority villages, by the end of 1974, most TCs were living in the North of the island, and most GCs in the South. These movements of population were not symmetrical mirror images of each other. Both ethnic communities were motivated by a search for personal security, but many TCs had been seeking this since 1963, when they retreated into small, defended enclaves, experienced the next ten years fear and extreme hardship, which they remember as "The time when we ate stones." Most GCs had only become aware of personal security issues after Turkey landed troops in the north of Cyprus in July 1974 and ended up militarily controlling 36% of the island, a matter deeply angering and humiliating to the Greek Cypriots, then, and now. This paper will focus on GC refugees from now, on and particularly those from a single village.

GC refugees had left behind homes, land, businesses. Although the GC government now presided over a great deal of property abandoned by TCs who were moving from South to North, the numbers of GC refugees were roughly four times greater than TC refugees in terms of numbers to be re-housed, and the need for agricultural land. One in every four GCs in the South after August 1974 was displaced. The economic implications of this political upheaval in the South were severe, and for a time the threat was major fiscal implosion. Many refugees had substantial business debts – farmers pre-war had routinely borrowed money against future harvests, and entrepreneurs borrowed money for business development, which they still owed. Civil servants and farmers had before the war borrowed money to build houses in which to start married life. Had Government wiped out all these debts, financial meltdown was a real possibility.

The national economy and state planners had then to deal with a number of interrelated issues – possible downward spiral of destitution and macro-economic collapse:

Loss of homes

Loss of productive lands
Loss of businesses and industrial sites
Loss of revenue from taxation
Loss of production capacity, and product.
Massive unemployment and underemployment.

The state produced several Emergency Plans which treated the refugees as a "development resource," [Zetter 1992; Strong 1999]] employing them and subsidising them in all kinds of ways. Space does not permit elaboration here. [**See Power Point Version**]

How did the consequences of displacement affect the villagers?

After initial flight, the villagers pursued their fortunes for some months in larger aggregates, grouped by the contingencies of flight and first places of shelter, and gradually as situations partially stabilised, started to break out into kin-based smaller groups, three generation families, with the procreative nuclear family as the middle , with dependent children, and sometimes dependent parents.

From then on each economically active man and woman looked out for opportunities individually, their priority being support to dependents. Some farmers looked for available land to farm – abandoned Turkish Cypriot land was one possibility; land which could be rented was another. Some farmers went straight into labouring jobs, for within less than two years of displacement in August 1974, there were labouring opportunities in infrastructural projects - refugee re-housing, light industry sites, road and airport construction.

In the 1930 Cohort Survey we asked informants about their pre-war occupations and their postwar occupations. There are two patterns in the refugee data – **occupational continuity** – many people find ways to continue to do what they did pre-war, [farmers farming, taxi-drivers and truckers driving] but there is also notable **improvisation**, depending on personal circumstances, and social and economic resources. There are two kinds of improvisation: farmers who went on farming, but switched from the long-term tree crops they had cultivated pre-war, to short-term crops, which are planted and harvested in a few months. The other kind of improvisation is where the core occupation is changed: a farmer who becomes a miner for some years, and later a car park attendant, or a farmer who becomes an odd-job man with a small pick-up van. Or a farmer who takes on a petrol pump franchise alongside his farming, and as he ages, phases out the first, more strenuous task. It needs to be said that changing livelihood activities, and combining them is not exclusive to the refugees – it was observed in pre-war Argaki, and is observable in non-displaced Astromeritis.

Argaki women pre-war had been divided into two main categories: those whose poverty forced them into the labour market as labourers, employed by the day to weed, to harvest, to pack produce, to work as shop assistants; and those who worked only on their own land, either as managers of labourers, or as farmers alongside their husbands, or without their husbands if these had other off-farm jobs. These better-off women would do unwaged exchange-labour with other households, a day for a day, but they would not accept money instead of the day's labour, insisting they must be repaid in labour. There was a hard status boundary they did not wish to cross between self-sufficiency and the public vulnerability of women wage-labouring.

In the new situation, many women who had not pre-1974 worked outside the household holding, for wages, came rapidly into the labour market, either as home-workers using sewing machines, or as labourers in small factories – produce packing being a common task. Cleaning, and cooking for schools, offices, doctor's clinics also were reported.

More analysis needs to be done in comparison with the non-refugee cohort. We can say with some confidence that the data on the educational levels and occupations of the children of the two cohorts show significantly more refugees achieving somewhat higher levels of both. The youngest "cohort" refugees would have been aged 34 in 1974, and their oldest children would typically have been 8, at most 10 years of age. We cannot say how far the differences are the result of pre-war or post-war trends. All that can be said is that the refugees' children did not collectively take major steps to downward mobility as a result of dislocation.

We asked the 1930-40 cohort informants to state the level of their childrens' educational attainments, and to describe their subsequent jobs. Virtually all children were more highly educated than virtually all parents, simply due to the national expansion of mass education in a period 1945 to 1990. We then gave 1 point to each child who continued at the same occupational level as its father [normally fathers were farmers, or artisan workers, 2 points if the child completed secondary school and took a white collar job, 3 points if the child did several years of tertiary education, and obtained a semi-managerial job, and 4 points if the child entered a profession.
The score per 100 children of non-refugees was 45 points, and for refugee children was 65 points. This rough-and-ready calculation suggests at very least, refugee children were upwardly mobile rather than downwardly mobile, and that they did better overall than non-refugee children. We think there is some association between rural residence of parents and remaining in more manual and artisanal occupations, for children.

We shall say nothing more about these adult children here. The focus will be on their parents, the 1930-40 Survey Cohort. No gender analysis of the children has yet been carried out.

Theme Two: Dispersion and the Conservation of Social Capital.

The pre-war fieldwork was carried out in 1968-73 in a growing, prospering, modernising village, where four out of every five marriages was between two people born in that village. Most people could trace either a distant consanguineal or affinal link to their spouse. The ideology of the village, familiar from villages all over the Mediterranean, was "We are all related here". Since the analytic framework chosen to understand the village took seriously the insistence of informants that the village excelled at conflict-management, and general solidarity, it probably ended up dazzled by this promotion of the village as phenomenologically and socially an all-important institution. This was not so much out-right wrong , as analytically insufficient, and somewhat misleading.

The problem can be glimpsed from 1969 field data, collected to explore the social destinies of larger and smaller kin groups. To get a measure of size, and generational fertility, people were asked how many first cousins they had, in the village, and outside it. Most people had most cousins within the village, but significant numbers outside. The range was from7 first cousins to 57. An average informant had 32 first cousins, of whom 23 were resident in Argaki, and 10 elsewhere, the result of marriage, labour migration, or both at once. This was

re-confirmed in 2004 by going through the birth cohort from 1930 to 1940 with some key informants, checking pre- and post-dislocation residence.

So, the theoretical and empirical question now raised by the dispersal of the villagers in 1974 is, what did that dispersal really mean for them? How important to individuals and families was the fact that they lived previously in compact highly inter-related communities before 1974, and that thereafter they dispersed to more than 25 locations in Cyprus, and to parts of Britain, Canada, and Australia, the Gulf, and elsewhere afterwards? Put crudely, how much do the refugees reify, talk up, dramatise, the "loss of community" when they look back? That it was an unwelcome shock, and temporarily disoriented and destituted them is not at issue. But can their self-images and memories be trusted? If we go beneath the passionate nostalgia, what's the score?

To give this some context: all over the world, in patrilineal clan based communities, women as individuals leave their natal families at marriage, often without wanting to, and go off to another household often in a place miles from their first homes. They tend to weep as they leave, and often complain of being lonely and disoriented. Their periodic return visits to family of origin are important to them. But they usually survive [if not victims of rare events known as "dowry deaths"] They expect separation, it is their fate, and they learn to deal with it. But any refugee would point out immediately that these situations are not truly comparable. The young bride knows she must leave home. She expects it. She has time to prepare herself. It is not a shock of the same order. The refugees left their homes at a day's notice or less. They were forced to leave in a quite different sense.

When talking about the costs of dislocation, most refugees put loss of productive land to the top of the list, and since all but 2% of households owned some irrigated land, and farmed it part-time or full-time, this makes sense. Both men and women talk a great deal about having laboured on their land to make it profitable. They reinvent the Labour Theory of Value. They then tend to stress loss of home, the house, the house they grew up in, or the house they built with their own labour or paid for, to start their marriages. Women are particularly emphatic about the loss of their homes.

The third thing which gets mentioned a lot is the village as a community of kin and neighbours. So, a woman will speak of being separated from her sisters and her neighbours. Men do not talk so much about separation from brothers, more about their parents and about friends and "co-villagers". Some of the refugee children born outside the village but growing up with these conversations about the special quality of social life, say they would like to experience such rich sociality, or conclude that the village was populated by a special kind of people.

When people fled in 1974, the flight was not a planned and cohesive collective action. At the end of a process which went on for weeks and months, nuclear families settled temporarily wherever there was shelter and, if possible, work or cultivable land.

Such settlement could not normally keep whole sibling sets together. My data suggest – impressions rather than rigorous - that where siblings are living in proximity they are more likely to be sisters than brothers. But the unit of settlement and survival was the nuclear family, often augmented with a parent or two. And here, a note of some importance. In the economic long haul, an able bodied grandparent in Cyprus is not a cost, but a benefit, because child care is vital for women's paid labour force participation, numbers of children

per family are now rather small - and the committed and unpaid labour of grandparents can make the differences between prosperity, or bare hand-to-mouth viability. Later if serious infirmity strikes a grandparent, the balance changes. In 1968 there were few old people's homes. Now they are common, staffed by labour migrants from poorer countries, some of whom ironically, are Tamil refugees.

So, as the village has never been re-aggregated, either by state planners, as happened among the Turkish Cypriots, or by the focused efforts of the dispersed villagers, people have gone on living away from each other, and with new neighbours. It seems an article of faith for some refugees to continue to insist that they have not got to know their diaspora neighbours well, a bit like those people in British society who used to say, apparently with pride "We keep ourselves to ourselves", that they regard them as "xenoi", strangers, and that nothing can compare with the social life of the old, lost village. But others allow that they have made good friends from chance refugee neighbours, that some of these people are outstandingly decent human beings, and that after 25 or 30 years in a new place, they have come to regard it as "home". Sometimes they mention that they have buried parents in the refugee diaspora community, and that this changes their attitude to the place. [See also, Zetter 1998] Sometimes they mention children or grandchildren rooted in the new place.

So, my modified viewed is that dispersal did indeed cause a separation of some relatives, of neighbours, and of friends, and did present people with the loss of a nucleated community, a village with a small church at its centre, with a patron saint offering spiritual protection to the society of the orthodox Christian faithful. If the core primary group nuclear family with husband's or wife's parents often attached, went on living together in its new location, with its new livelihood activities, and sometimes coping with a migrant husband/father] then in general, the wider secondary and tertiary sociality of village life was lost. But more on this in a moment.

However, this lost was relative not absolute. The issue is part theoretical, part technological, part how villagers actively overcame separation.

Theoretical, first. **Pre-war,** any out-migrating, and out-marrying villagers had in fact to lose, in the day-to-day interactive sense, that very easy sociality they had grown up with. But they survived. It was available to them on week-end return visits. They were not scarred or traumatised. They adapted, learned new villages, or urban lifeways. They were not compelled to make those moves, and that is important. But people have been more flexible and robust than the refugee emphasis on continuous local sociality would have us think. The refugees' discourses of loss **dramatise and amplify** what has been lost, and **idealise** it too.

Secondly, the technological input. In 1970 in Argaki, there were three private telephones, and not more than 20 private cars, for 350 households. Over the first 20 years of dispersal, 1974 to 1985, telephones in homes became commonplace, so did owning cars , and roads in all directions improved. So, it became easy to talk to close kin, and not impossible, in a small-scale island, to visit them. There were costs – time and money, - but the technological and economic changes did something to blunt the cutting edge of social separation, which in any case, is here argued to be secondary, a kind of social luxury, not primary, in the sense that the nuclear and extended family is primary.

The third factor is how the villagers worked socially as opposed to technologically, to stay in touch, call it conserve social capital if you like, and overcome the scale changes which

separation had created.They did this through participation in weddings, and in funerals. Cypriot weddings act as a rotating credit fund for the newly-weds, and involve long cycles of reciprocity which have grown as the island became wealthier, and more and more guests attend weddings. Where a village wedding in the 1930s involved "close kin" and seem to have been attended by numbers of people between 30 and 60, celebrated over a week, by 1970, the whole village attended, and each family made a cash gift to bride or groom. There was a strong moral compulsion to attend, and to send the cash if attendance was not practical. In 1975, when as newly displaced refugees, people were taking stock of what they could and couldn't do, a village woman in the mountains sent a message to a much wealthier and higher status woman in Nicosia. The message was "I am marrying off my daughter on the 22 of the month. I came to your daughter's wedding, and I expect you to come to mine." The fact that the wedding referred to had taken place more than twenty years previously made no difference. As the bearer of the message, I was then co-opted by the Nicosia woman to drive her to this wedding, where she made her gift, but did not deign to stay for long.

These practices continue. Great trouble is taken to deliver printed
invitations to everyone from the village, and in general, people know where to find many co-villagers or how to communicate with them. How systematically they do this is not clear; they do it lumpily,to get their own core people, picking up many friends by snowballing methods, and missing out socially marginal people, and odd outliers.

The details of the wedding celebrations need not detain us here, but they are serious moments of display and pride in the lives of parents and their children.[See Argyrou 1996] In the hierarchy of Cypriot Greek values, the two highest are first to educate one's children, and secondly, to see them marry well.

Participation in funerals is less systematic, and involves a small flower offering,often presented in person, but also by proxy. In a recent Argaki funeral observed, the flowers filled the back of a small pick-up van. Your presence is the larger gift, as it were. And whereas a wedding invitation is planned and delivered weeks in advance, funerals tend to be at shorter notice, and one learns either from an announcement in a newspaper, or from a phone call. The obligation on close kin to attend is very strong, but extensions to the wider community are less compelling. What is important is to telephone commiserations, or to remember next time one meets to commiserate. It was notable that when the Cease-Fire line separating Turkish Cypriots who remained in Argaki village from the Greek Cypriots opened up last year, and the Greeks made return visits, the older Turkish Cypriots made a point of showing their Greek visitors that they had heard about recent deaths among the Greeks, and that they had shed tears for them.

Roger Zetter,[1998] an astute commentator on Greek Cypriot refugee adaptation has asked why it is that refugees go on making much out of weddings and funerals of fellow villagers when the physical village is no longer the basis of their lives. He regards the rituals as "emptied of symbolic content". This seems to me to risk missing the anthropological point. Villages are sites of relationship, and yes, houses and productive land underwrote those relationships. But the relationships were based on biology and social organisation, and they do not lose their meaning because of the loss of the original material facilitation bases. Perversely, if you like, they receive added significance because of the material losses, especially when supported by material telephones and material motor cars, and material gift giving cycles. People need the financial participation more than before, not less.

This concludes "Social Capital", but it has important implications for section III.

Theme Three: Questions of Comparative Health.

In 2000 when the current phase of field research with Argaki people started, they pushed the idea that being refugees was bad for their health. This came up in several contexts. Where people had died since 1974 of heart disease or cancer, there was a tendency to suggest this was from the difficulties of refugee life. A particular Greek word anchos was often used. This word is now commonly used in newspapers and popular speech to cover the semantic field of the English word "stress". The English words anxiety and anguish, the French angoisse, the German angst point back to Latin and Greek derivations. The Classical Greek gloss on anchos suggests extreme pain, the sensation one might feel if pierced by a hook and then hung on it.

Another context was a more general tendency to discuss any major illness as stress-related. People said things like "The refugees pass on sooner". A small number [3 or 4] of refugees had died from diabetes and depressive alcoholism.[out of a cohort of 250] People spoke of them as having been unable to cope with the challenges of refugee life.

But were they right? That is, would these people have found non-refugee life equally stressful and drunk themselves to death quite young? Perhaps the refugee factor shortened their life by a few years. But how many?

One complication, or "confounder" in medical jargon, is that the refugees have shown a tendency to splitting their lives into two dramatised narrative halves, Before the Fall, and After the Fall. Before was Paradise – that is how they often described their villages of origin. Everything was going fine. After 1974 and the shock of dislocation, they were expelled from Paradise, and have lived somewhere East of Eden, my words not theirs, and things have been seriously hard. With such a White-and-Black perspective it is easy for anything unwelcome which comes to you to be perceived and narrated as post hoc ergo propter hoc, after this and so because of this. That is, Dislocation is blamed for all ills. This presents the analyst with difficulties. How can we know which aspects of difficulties are wholly, mostly, partly, or hardly due to dislocation? How do we know if this death at age 64 of a heart attack would have happened at this very moment anyway? The epidemiologist who does not engage with single instances anyway might ask, was there a history of heart disease in the family? Were there dietary changes as a result of dislocation? Did people work harder? Was there any predisposing trauma in early life which made heart disease more likely? But to answer such a questions rigorously, a study would have had to have started close monitoring 30 years ago, and repeat interviewed every 10 years. Such a study never crossed my mind when first working with refugees- there seemed more pressing issues, then.

The refugees' suggestion that being a refugee was bad for their health led to reading on stress, on Post Traumatic Stress Disorder, then to studies of cardiovascular disease, and to Michael Marmot's Whitehall study, a longtitudinal study of civil servants at six levels of responsibility, which suggests that the more people experience work demands which they cannot control but must respond to, the more likely they are, everything else being controlled for, to develop heart disease. Marmot's work is rigorous.

In general, says Marmot, 50% of major CV illness is explainable by family history, diet, smoking, and lack of exercise . The other 50% is up for grabs. Work place demands are one

strong candidate. The other big candidate is Major Life Event stresses, such as untimely death of close relatives, relationship break-up, bankruptcy, job loss and subsequent long term unemployment.

Another candidate factor to explain CV disease is the intensity of social inequality. Richard Wilkinson's Unhealthy Societies generated a good deal of research, some confirmatory, some critical. [Special Issue, Int.J.Epidem.2000] He and Marmot have at times joined forces to promote arguments about social determinants of health and illness.

In general, clinicians agree that big emotional upheavals can trigger cardio-vascular crises. However, in the general literature on social factors in heart disease, refugees as a vulnerable group do not get much mention, so it still seemed important to see if they are "more at risk". [See, for example, Berkman and Kawasaki,2000]

The literature on Forced Migration and Health held at the Refugee Studies Centre QEH Library -some 770 references in 2002, had two themes: Humanitarian Emergencies in refugee camps, and the toll of infectious disease, malnutrition. The other theme is Post Traumatic Stress Disorder.[PTSD] Important exceptions –Clark, Colson et al 1995 who showed that Tonga male forced migrants had a period of increased death rates. Rack 1988 is a study of Polish refugees in a small U.K. town, their general and mental health. But in general the possibility that long-term refugees might be high risk for cardio-vascular illness has not been much discussed, although there is a large literature on voluntary migration and physical health.

The specific issue in Refugee Health be thought of as a "nested" issue inside:

1] Refugee Health Generally,
2] Heart Disease in particular:
3] Heart Disease and Migration
4] Heart Disease and Forced Migration.

I looked for data in Cyprus which would address the issue of refugee and their physical health. The Cyprus Ministry of Health had no comparative data which sorted refugees and non-refugees, and the issue seemed uninteresting to non-refugee officials, but very interesting to from refugee doctors who often produced striking personal anecdotes. The Statistics people at Ministry of Interior could not at a quick inspection see any spikes in death rates when we might have expected had there been higher refugee mortality in 1975-1980. They said, these would be very small numbers, and that is probably true.

I tried two graveyard counts,[one refugee graveyard, one non refugee graveyard] but they did not yield well-defined data sets. As far as could be worked out, refugees might have been dying on average one or two years "earlier" than non refugees. But this was a very doubtful procedure since there was no clear cohort basis for comparison, as LSE colleague demographer Christopher Langford made clear to me.

An ongoing study of diabetes prevalence in Cyprus has been persuaded to include questions on whether the 1200 randomly sampled respondents are refugees or not. This may pick up some material on long-time refugees and heart disease as well as refugee blood

pressure and diabetes. But of course it won't tell us about people who have already died "early".

Finally, after several demarches, I obtained a small grant from ESRC to find some data which might answer the following questions:

1] Had there been more early mortality in the refugee village? Hypothesis 1 [derived from all kinds of arguments in the literature] was that the refugees would indeed show more early mortality!

2] Had there been more serious cardio-vascular disease among the refugees?

3] To see if any other serious disease patterns distinguish the two villages.

Methods

To identify the 1930 survey cohorts, the following procedures were followed:

A. The birth registers for the years 1930-1940 for both villages were obtained. The birth registers were then checked with the help of key informants, to remove cases of childhood mortality, and of mortality prior to 1974, the study's "start date" . For Argaki childhood mortality ran at about 20% of all births. In the mid 1930s there had been a typhus outbreak, and cholera too. TB was also not uncommon.

B. The birth registers were also evaluated to remove all cohort members from both villages who emigrated for work or marriage, prior to 1974. This was so that our study would end up comparing two populations who were as near as possible identical except for the fact of dislocation and subsequent life courses.

C. The recent electoral registers for both villages were obtained. The Argaki refugees are located in more than 25 different places in Cyprus, [towns, suburbs, villages] but the electoral register continues to group them in a continuous series of 54 pages, under the heading of Argaki village. Each page containing 25 or more names, 1350 persons of all voting ages, classified by their pre-refugee village of origin, but then providing their new locations and street addresses. Date of birth is provided in the electoral register, and we identified all persons born in the eleven years 1930 to 1940, inclusively. The total for Argaki was 253 names. From the electoral register we discovered some persons born in the respective villages, but missing from the birth registers. There is no reason to be suspicious of these identifications, and in the case of Argaki, the individuals were often known to the senior investigator, who had in 1968-69 conducted a detailed survey of 200 male household heads, and a key-informant estimate of basic demographics for the remaining 112 households. He had also walked the village and identified every house and its household head.

D. Local telephone directories were used to confirm identifications, and to make interview contacts. Some people were interviewed in person, some by telephone. Most of the non-

refugees were interviewed in person, and about half of the refugees. In generally, face-to-face interviews were much more satisfactory, but some telephone interviews worked well.

The remaining persons known to have been alive in 1974, and then resident in the two villages were the theoretical total population, for interview. We crucially sought information on those who had died after 1974, as well as the living**. That is, living and dead persons were equally "cases".**

For Argaki, we have collected information on 137 subjects, living or dead. This is 73% of the possible total who should have fallen within the scope of the study. Those not interviewed were people for whom an initial telephone contact had proved elusive.

For Astromeritis, we have collected information on 105 subjects, living or dead, which is at least 85% of the possible total. The remaining 15% were not traceable, or did not have an identifiable relative for even a proxy interview.

The findings so far are like this:

Table 1:

Base number	137	[100%	105	[100%]
Cardiac	5 +2	[5.8%]	5	[4.7%]
Cancers	6	[4.3%]	3	[[2.8%]
Diabetes	2	[1.4%]	0	[0.00]
Other	4	[2.9%]	9	[8.5%]
Total	19	[13.8%]	17	[11.3%]

Comment: These data do not support the refugees' belief that they have so far died "earlier" than non-refugees. The differences are not significant. It is possible we have failed to identify some refugee deaths.

Table 2

Base number minus deaths in study period	120	[100%]	88	[100%
Major cardiac	19	[15.8%]	7	[7.9%]

Medium cardiac	21	[17.5%]	11	[12.5 %]
Cancers	7	[5.8%]	1	[1.1%]
Diabetes	4	[3.3%]	10	[11.3%]
Other				

Comment: Table 2 shows that refugees have markedly higher rates of cardio-vascular disease compared with the same age-group of non-refugees. The Chi Square test of significance yields P = .01

Note we excluded episodes of raised blood pressure in and of itself. For elevated blood pressure to be included as medium cardio-vascular illness it had to have been prolonged and medicated. There were at least two alcohol related deaths, which could have cardio-vascular related causes, and/or diabetes. But they have been listed as "other" to avoid bias towards the expected conclusion.

We cannot make a strong interpretation of this suggestive finding. This is a small scale study of two cases. Were the findings to be repeated in sufficient cases they would be considered interesting but not surprising by those concerned with cardio vascular disease. But we hope they will encourage others more concerned with forced migration to take further the question of whether refugees are a category particularly at risk of cardio-vascular disease.

However, there are some leads in the existing literature which would need to be considered in a large-scale study, with causal ambitions.

One might, for example, cite earlier workers, such as Appels and Mulder [1988] concerned with excess fatigue as a likely precursor of myocardial infarction.

Because several different conditions can produce feelings of "excess fatigue," rather sophisticated studies are required to filter out key factors. Certainly, refugees in Cyprus have had " a long-standing problem they have not been able to solve, " and both real and symbolic losses, factors flagged up by the authors are accompanying "excess fatigue" reports. Other studies suggest that persons who experience anger intensely and frequently are more prone to cardio-vascular illness. Refugees often show anger when they recall their displacement, and they have well-developed feelings that it was and is a matter of lasting injustice.

There could be a number of other well-established candidate explanations for the higher rate of cardio-vascular illness in the refugee group.

1] dietary? It is possible that as Argaki village developed economically faster than Astromeritis, in the years 1964-1974, our Argaki cohort had a higher meat consumption in the ten years preceding their displacement. That might account for the current differences. It is so long ago as to be virtually unresearchable by recall methods.

2] longer working lives? Since the Argaki cohort were largely destituted in 1974, and in most cases had dependent children to provide for, they may have worked longer hours, on a daily, weekly, monthly, basis, and they may have added extra working years to their lives.

3] loss of control? The experience of dislocation and destitution would, we suppose, be experienced, at least for the initial years before economic recovery was starting to seem possible, as the sense of "lack of control over workplace conditions" which is part of the Marmot Whitehall civil servants propensity to cardio-vascular disease.

Here we must leave the cardio-vascular data.

We have no explanation for the elevated diabetes rates in the non-refugee village. The cancer data are not statistically significant , but we have plans for subsequent work with a large data set of breast cancer cases on the National Register.

Table 3/

SIGNIFICANT ILLNESSES IN LIFETIME	**REFUGEES %**	**Non REFUGEES %**
0	28	16
1	47	28
2	17	32
3	6	12
4	0.8	9
5	0.8	2
Exclusions :	appendectomy	appendectomy
	tonsilectomy	tonsilectomy

short-term higher blood pressure episodes

inclusions : raised blood pressure with medication;medication for "stress" for one or more years; typhus in childhood; any cancer episode even if "cured"; arthritic conditions with medication, or surgery.

These findings are unexpected. We had supposed that the refugees would have reported more illness across the board. But the patterns are not so:

1] more refugees than non-refugees reported no illness

2] more refugees have a single illness only, rather than several.

3] more non-refugees have had two, three or more illnesses.

5] More refugees have or have had one of two life-threatening illnesses - cardio-vascular, or cancer

6] More non refugees have one other life-threatening illness – diabetes.

Of particular interest are data which suggest occupational links – arthritic and other painful conditions of arms, shoulders, knees, and feet, with concomitant operations, particularly

among male farmers, women farmers, and women factory workers and seamstresses using sewing machines. So, there are potential links to "the labouring body", and to literature on occupational illness. Mostly, these conditions are discomforting, and disabling, and sometimes "limiting", and they have implications for employment patterns, and disability payments, but they are not as urgent a threat to life as cancer, cardio-vascular and diabetes.

It may be that the refugees who have worked more years, or more hours per day, have more physical difficulties. We have not collected data which is sufficiently refined to answer that question [or a number of others we would dearly like to answer] rigorously. Refugee narratives often feature people working very long days, or two jobs. We might do a re-study on this issue with a small sample from each of our larger samples.

Mental illness

We have some information about mental illness, particularly depression. We asked people to mention any incapacitating illnesses, and we prompted many of them with the Greek word for depression – katathlipsis, explaining it as an emotional condition which stopped you working and sent you seeking medical help. People reported much unhappiness when they first became refugees, but insist they had "too much to do" for clinical depression to take hold of them. Depression is understood to be illness, not lack of character, or an affliction related to evil doing or sin.

It is worth comparing briefly at two important anthropological studies which touch on social disruption and mental illness.

The work of Arthur Kleinman, the anthropological psychiatrist who has worked extensively in China, is the gold-standard in this area. He was dealing with a sample of people referred to a Hunan clinic for mental illness. In China at the time of this study – the early 1980s, there were high numbers of diagnoses of neurasthenia, which is physical-symptom led, and few for depression, which to the Chinese doctors then was mental-symptom-led. In the USA these relations are the reverse – many depression diagnoses, few neurasthenics, a diagnosis regarded as old-fashioned and lacking in specificity. Kleinman suggests that because the communist state made it seem deeply irresponsible to be sick for psychological reasons – it looked like a weakness of will, ideological defection, or both – people faced with hugely demanding work-place difficulties presented themselves with symptoms which led to the socially-legitimate diagnosis of neurasthenia. Kleinman wished to see if Chinese neurasthenics respond well to anti-depressant medication, and it turned out that many did, so something was learned about both cross cultural diagnostic categories, and underlying, more universal illness syndromes.

Much influenced by Kleinman is Vieda Skultans' study of Latvians who had been through several major upheavals in their lifetimes. Nazi occupation, civil war ,Russian Communist occupation, and the hardships of Stalinist authoritarianism. Skultans was also intrigued by reports of "neurasthenia", also used in Latvia and meaning, physical symptoms such as severe tiredness, headaches, loss of appetite, and loss of self confidence and drive. Not only this, but a number of her informants described their lives as incoherent and meaningless. Latvians also spoke a lot about "oppression" as key themes making them ill, and saw their own illnesses as mirroring wider societal malaises. Skultans did not find much severe mental illness – two cases among 30 cited informants, a majority of whom were women, most of

whom had living children, a point I shall return to in conclusion.[Skultans, personal communication]. People often told her that their nerves were shattered, but, she says, this did not mean they didn't function. "I think they were making a connection with national identity and damage to the nation."

Greek Cypriots speak about their world being brought low through Turkey's occupation of their properties, and what they see as the lack of concern in the international community for injustice. They see themselves people for whose human rights the world no longer cares. And they believe that no society in the world has suffered so much from these anomalies as Cyprus. Their view is uninformed by the huge difficulties of refugees in many African states, and even though Lebanon is 20 minutes away by air and experienced a 15 year civil war, the Greek Cypriots hardly remember this. They have a Cyprocentric view of their victimhood. They are an Orthodox People, God's people, forgotten by the world. Their view may be lacking in balance and realism, but it is coherent and meaningful to them. It is ring-fenced by the political system and the elite who lead it.

Among the Argaki refugees I logged three cases of depression, two men, one woman, of which two clearly had had pre-war onset, and two cases of men who apparently drank themselves to death, which might have been accompanied by depression, and diabetes. There is another diabetic with incipient alcoholism in the survey. There were certainly two people, a married couple who had lost a child unexpectedly through leukaemia , and would probably qualify as chronically but mildly depressed. The man said "We had just about got over being refugees when we lost him. That is something you never get over."

In general people reported although they had been very unhappy, and had grieved the loss of their village, they had never been unwell enough to stop working and to seek medical treatment for their condition.

If we compare them to the Latvians or the Chinese, Greek Cypriot refugees experienced nothing as terrifying as the Cultural Revolution and the great famine, still less the Latvian upheavals. They experienced a short, deeply unsettling upheaval,with specific losses – property and communitas, and then were able to take a relatively predictable, slow , hard-working, road to recovery. Core values were not made meaningless. Means to achieve goals were left within the grasp of the able-bodied, and "strong minded". Greek Cypriots would say "strong souls".

In his neurasthenia study he has chosen to work with people referred for illness, and Skultans has followed him in that - she advertised for people who had been given the "neurasthenic" diagnosis, which she notes is not stigmatising in Latvia at that time. Our method has been different: We have started with a notionally normal birth cohort of people and tried to work out the illness rates and types of attrition, from a particular moment in time when for one group, a great deal changed in an unexpected and disruptive manner.

Kleinman argues that we need to " collapse old dichotomies – for example, those that separate individual from social levels of analysis, health from social problems…"

And he thinks anthropology and social medicine should be in close alliance. [Kleinman, Das and Lock 1997:x] . That is what has been attempted in this paper. [1]

Theme 4: Coping and Transcending: Emotional and Expressive Responses.

There has recently been a major change in refugee health studies. F.L.Ahearn Jr' edited volume Psychosocial Wellness of Refugees. is largely about methods, has nothing on cardio-vascular illness, and is mostly about psychological illness. But its very title makes an important point – most refugees cope, survive, act purposefully and effectively. The many who do well in health and broader adaptive terms are just as important as the few who do not,both to themselves, and to us, as analysts. Both are equally important. This follows up on important early work by Kinkle and others, on the major differences in how groups of people deal with challenges to health. What protects people from illness?
Why not **more** cancer and heart disease? Why not "more mortality"?

There are numerous studies of refugee and migrant health in Canada, USA, Australia and Europe. Many of these studies record the differences between migrant health and that of the host population. Some try to compare migrant health with health of non-migrants in their communities of origin. One of the difficulties about the first kind of study is that the migrants/refugees experience a range of complications to the initial dislocation, and commonplace destitution:

Refugees who migrate will often have to:

1] use a new language
2] live in an unfamiliar society
3] face labour market disadvantage/discrimination/downward mobility
4] face forms of racism and denials of their legitimacy.

So Cyprus allows an unusually clear test of "simple" forced migration as generative of difficulties, since factors 1 to 4 are basically not present.

In Cyprus, post 1974, the cultural ethic that parents must work hard to educate their children was seen as a shared, consensual and internalised norm, rather than a value imposed from above by party and state. If there was not more mental illness, I would argue it is because although people were stretched and tested, but not broken by what was required of them. It was, in the main, within their power to succeed.

Comparing to the Latvian and Chinese cases, with the Cyprus case, if we wish to look for "protective factors", for reasons why people who were dislocated, do have not more major health difficulties, such as clinical depressions, the following reasons are proposed:

1] They were received into a sympathetic state and society of co-ethnics, co-religionists, which also made available significant resources.

[1] Agathangelou & Killian 2001 found that 22% of their refugee samp le were suffering from Post Traumatic Stress Disorder, but that many of these people had lost a close relative in 1974. Few of our refugee informants had lost a close relative in the 1974 conflict. We did not ask PTSD-oriented questions, so we cannot comment on whether or not Argaki refugees would if asked eliciting questions, show evidence of PTSD. We noted earlier that the refugees attribute many health difficulties to "angkos" – "stress".

2] They retained their pre-dislocation life goals – educating their children and seeing these children marry. Given a slow reduction in completed family size, generally positive economic growth, these goals were attained for most people, sooner or later. That allowed people to keep their self-respect as adults.

3] Their life-goals are diffuse enough to accommodate a relative shortfall: If a child graduates from secondary school, this can be considered as "education" even though the parents and child in question cannot go far into tertiary education.

4] Laughter: there is growing medical and psychological interest in laughter and humour as protective of health. This is not to suggest there were many laughs in the early years of exile. Such laughs as there have been have been "late onset".

Two laughter vignettes:

First : P and T , have had a hard time of it, he on a low salary, she having to pay back the loan for her pre-war dowry house before the house she now lives in, developing high blood pressure. There was bitterness, and disorientation in 1975, and T's responded angrily when asked if he would adopt a child from his sister, whose husband was a war casualty, leaving her with eight children. He said then with unusual feeling "Can't you **see** the state we're in?" Now, in 2003, we sat quietly in their house, drinking moderately and eating sensibly, as people of our age do, and they remember 1975 and being refugees, and find things to laugh about. P laughs about being offered tins of bully-beef by the Red Cross. T laughs about having only one shirt which had to be washed each evening until a fellow villager drove by at the wheel of the Red Cross lorry and threw him a second shirt. This was a technicoloured teenage garment, which he would never have chosen for himself. But at the time he was glad of it, because his one shirt had to be washed out every night.

So, the pains of dislocation can be remembered many years later and re-presented with laughter. That is, in some sense, moving on, and getting on top of what once threatened them so powerfully.
That is not to say they laughed their way through the previous years, but they did not lose the capacity to laugh. Later, when I saw the wedding of their child there was collective energy which suggested enduring strengths.

Second: TD is 82, a survivor of recent surgical aortic spasm repair.
His wife A, is from a family where the women give each other the giggles, and everyone laughs uncontrollably for five minutes. Including TD. Which is clearly good for him, as he forgets to be the serious communist militant, a mask he has worn with dignity for a long lifetime and joins them in mirthful helplessness.

A tries to keep him from drinking too much, and he plays games with her. She says, "If you go and die on me, I'll find another husband" and he says "Go ahead – I shan't be around to get upset, anyway!" and they both laugh some more , as they know that it is an unthinkable event in a Cypriot village for a 70 something widow to re-marry. She is actually still a bit cross with him because she is scared he might die and leave her, not "alone" as she has a daughter 100 yards away, a son 15 minutes down the road, two more children and numerous grandchildren. But his death would leave her without her life-companion for whom she cooks , and washes, and creates order without a sign of feminist rancour, except when he has

his nose in a newspaper all day, and won't chat with her. His death would leave her life with much less purpose.

He said, when still early convalescent, clearly very shaken by his near-death crisis "Life is sweet, and no-one thinks otherwise."
Agamben starts his disturbing book Homo Sacer with a quote from Aristotle to the same effect. His complex argument is about refugees treated as persons without rights, an argument made by Hannah Arendt in 1951. It clearly applies to many situations. The point is the Greek Cypriot state did **not** treat the GC IDPs from 1974 as people to be disregarded, kept in camps, or further marginalised and humiliated. It did not give them what Agamben terms *la vita nuda*, awkwardly rendered as "bare life". It protected their citizenship rights, and offered some extra refugee benefits, helped them up off their knees, and they have stood on their own feet ever since. But if one of the "hidden injuries" of being a well-supported refugee is an increased risk of cardio-vascular disease, the risks for the "bare life" refugees in Africa, Bosnia, and many other places may be very much greater. That is why we hope that other people can follow up on these suggestions, with bigger samples and more rigorous research designs.

Conclusion:

Economic success for many; economic flatlining for many others ; economic downward mobility for some; effective goal attainment and thus self-respect for most; some social capital costs partly offset by technology changes; a political culture which dramatised and amplified the sense of grievance and injustice; some serious health costs, but perhaps not as serious as they themselves supposed; and outpourings of expressive and creative activity, from the education of children, nurturance of grandchildren to poems, laments, books, newspaper articles, and much more which marked engagement with and partial transcendance of a major disruptive life event. But not without hidden health costs, which would probably have been much greater in a failing state.

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