

Hearts, as well as Minds: Wellbeing and Illness among Greek Cypriot Refugees

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Recently the psycho-social health of refugees has rightly received emphasis, but the physical health of long-term refugees warrants similar attention. This paper uses qualitative and quantitative data on informant-reported health outcomes for two Greek Cypriot village cohorts, one displaced, the other not displaced. Supplementary data from a national diabetes prevalence study confirmed a possible link between refugee status and greater probability of cardiovascular illness. Depressive illness also seemed higher among the refugee village cohort. But it is not only the illness of some of these refugees, but their surviving this, and the comparative wellness of others which is important, compared with the 'demographic shock' victims of post-socialist Europe, 1989–1995. The paper suggests why the Greek Cypriots have done rather better in health terms than the post-socialists of Eastern Europe, 1989–1995, but argues that refugees in failing states may have much worse health outcomes.

Keywords: refugee health, reported cardiovascular illness, Greek Cypriots, wellness, protective factors

Introduction: Some Key Issues in Refugee Health

Biomedical Emergency Health

The literature on refugee health shows two clearly marked main trends. The first is largely bio-medical, derived from humanitarian interventions in the early phases of refugee displacement, and it particularly concerns infectious diseases, such as cholera and typhoid, and nutritional status. Much of this literature concerns people who have come into refugee camps, or feeding centres, and remained in them for periods of weeks and months, sometimes years (see e.g. De Waal 1989).

Psychological Consequences of Displacement

The second trend involves psychological consequences of displacement, and of the violence which too often goes with it: experiencing or witnessing

torture and rape, and for survivors, loss of close family members or friends by violent death. This literature is concerned with psychological conditions, including Post Traumatic Stress Disorder (PTSD), and sometimes depression (Ager 1994). The general thrust of the PTSD literature is towards refining diagnostic instruments and treatments, and with the all-important matter of cultural differences and cultural meanings in perceptions of and management of psychosocial illness. But attempts to understand causes of serious psychological illness have developed a strong interest in social and contextual factors.

Brown and Harriss (1978) pioneered a 'severe life events' approach to depression and developed a rigorous methodology, reviewed by Creed (1985); some recent attempts to analyse PTSD have also developed sophisticated instruments and applied a range of statistical tests (Agathangelou and Killian 2002). They found that 22 per cent of their Greek Cypriot refugee sample were suffering from Post Traumatic Stress Disorder, but their data revealed that many of the PTSD respondents had lost a close relative in the military conflicts of 1974, so their reactions could equally well have been interpreted as reactions to the specific experience of untimely bereavement, rather than the more general experience of forced migration alone. Summerfield (1999) and R. K. Papadopoulos (2002) have cautioned against a too-easy assumption that PTSD will be an inevitable consequence of exposure to war. Skultans (1996) in her impressive qualitative study of Latvians who had been through several major upheavals in their lifetimes, suggested links between social disruption and psycho-social perceptions. A number of her informants described their lives as incoherent and meaningless. Skultans did not find many instances of severe mental illness—two cases among 30 informants. Most of her informants were women, and most had living children, a significant point we shall return to in our conclusion (Skultans, personal communication).

Physical Health: an Under-researched Area

The physical health of long term refugees and forced migrants, in comparison, has a much sparser literature. Mackay (1974) was a pioneering study; Clark *et al.* (1995) examined the health profiles of 10,000 displaced members of the Tonga ethnic group, in Zambia, and found significant increases in male death rates after displacement. Omidian (1996) studied self-reported physical and mental health of Afghan refugees in California. But Berkman and Kawasaki (2000) in an important benchmark volume made no reference to the issue of refugee health. Ahearn (2000) drew attention to the comparative wellness of refugees.

Research in post-socialist Europe (e.g. Eberstadt 1994; Cornia and Paniccia 2000; Marmot and Bobak 2000; McKevitt *et al.* 2003) has addressed demographic effects of social, political and economic upheaval rather than forced migration as such. However, it is arguable that such

upheavals are comparable in destructive agency to forced migration, and not unlike it. Typically, personal and familial destitution, and systemic economic collapse are followed by increased mortality, morbidity, and distress migrations.

Cardiovascular Illness

There are clues in the literature which suggest that cardiovascular illness might be particularly likely to affect forced migrants. Clinicians have for a long time accepted that profound shocks could trigger episodes of cardiac illness. Jenkins (1976) and Appels and Mulder (1988) were concerned with excessive fatigue as a likely precursor of myocardial infarction. Another strong candidate for explaining increased risk of cardio-vascular illness is the inability to control demands made upon one in the workplace (Marmot *et al.* 2000).

The Origins of this Study

During Loizos' qualitative field research in 2000, which focused on generational differences among refugees who had been displaced for more than 25 years, a health-related refugee narrative emerged with two strong themes. The first was recourse to the Greek word *angkos* ('stress') to describe the conditions of their lives in exile. Health problems were routinely explained by 'stress'. But in addition, when the deaths of co-villagers were mentioned, it was often suggested that these deaths were untimely. 'The refugees pass on more quickly', people insisted on many occasions. There were several striking examples of men who had died in their 40s and 50s, sometimes with diabetes and heavy alcohol consumption as part of the picture. As life expectancy in Cyprus had been pushing up towards 78 for men and 80 for women in the late 1990s, these did indeed look like premature deaths. But a handful of cases do not make a trend.

Greek Cypriots, the subjects of this study, are rather health-conscious (Mavreas and Bebbington 1988). I. Papadopoulos (1999: 188) reported that of her sample of Greek Cypriot migrants in London (which comprised both refugees and non-refugees) 88 per cent had had blood pressure checks, and 27 per cent had had cholesterol checks, while significant numbers had had primary health care advice in the previous twelve months on matters of exercise, smoking, alcohol, weight and diet. 34 per cent of her sample consulted private doctors in London, although entitled to free consultations with National Health Service doctors.

It was decided that a more systematic approach to the issue of the health consequences of long-term displacement was called for. On the one hand, what the refugees asserted was consistent with certain emphases in the literature on both cardiovascular illness, and psychological illnesses. On the other hand, Cyprus had been a relatively highly-developed country in 1974, and after a brief period of massive disruption, the Greek Cypriot

Government had made very thoughtful economic and social provision for its displaced citizens in the area under its control. It had subsequently enjoyed a period of rapid growth and prosperity. Refugees had been entitled to free health care, and the small scale of the island meant few citizens were more than two hours away from an intensive care unit. In Cyprus, the Greek Cypriots were legally 'internally displaced persons' who had been sympathetically received by their co-ethnics, and seen to have an entitlement to significant societal support.

The Government of Cyprus had not routinely published statistics in which refugee and non-refugee health outcomes could be compared, even though Evdokas and colleagues (1976) had given early warning that psycho-social and health related issues might be important for the displaced. A study of smoking prevalence in Cyprus made no effort to distinguish refugee and non-refugee smoking patterns (Government of Cyprus 1999).

Recently, there have been calls for closer attention to the health of migrants and refugees (Council of Europe 2000; Kliever and Jones 1999) and there have been some exemplary studies combining qualitative and quantitative work on small populations (e.g. Powles 1997, a study of non-forced migrants).

Greek-Cypriot Refugees, 1974–2004: Economic and Social Influences

In 1974, at least 165,000 Greek Cypriots from Kyrenia, Karpassia and Nicosia Districts left their towns and villages of residence, and re-located at short notice in the south of the island. In the first two years of their displacement there was massive economic disruption, but the Government of Cyprus drafted a series of Emergency Plans which treated the refugees and their productive capacities as 'development resources' (Zetter 1986, 1992; Strong 1999). These involved rebuilding infrastructure, business start-up loans, export credits, selective debt write-offs (for farmers) and job security for displaced civil servants. By these and other pro-welfare methods the state and the refugees together slowly and painfully turned a political and economic disaster into a process of reconstruction.

There had been a growing tendency for children to be kept in secondary education as long as they performed well; villages produced significant numbers of university graduates in the late 1960s and early 1970s, studying medicine, law, accounting and engineering. Completed family size was falling rapidly between 1941 and 1971 (St. John-Jones 1983).

When war came to their village in mid-August 1974, the Greek Cypriot population of Argaki sought refuge in some 25 different localities in Cyprus, and some families emigrated to Australia, the UK or Canada. Some men went to socialist countries or the Persian Gulf as short-term labour migrants (Christodoulou 1992; Loizos 1981; Strong 1999). For the next 30 years, these people have lived outside their village of origin, and while the hope of return has remained a political possibility for them,

all negotiations between the Greek Cypriots, and Turkey and the Turkish Cypriots have failed.

In the first months after flight, most Argaki families were in a condition of total or near destitution. But there was no starvation or epidemic disease outbreak due to the efficiency of humanitarian relief and the protective attitude taken by the Greek-Cypriot Republic of Cyprus towards its displaced co-ethnic fellow-citizens. The immediate concerns of the first months were cold, the difficulties of living in overcrowded conditions (Eliades 1982; Loizos 1981), and the future.

Gradually, whether in months or a year or two, most adult refugees re-started productive activities, and were able to focus on the tasks of re-housing themselves, providing for their dependents and planning for an uncertain future. The key uncertainty was whether or not they would return to their communities of origin. There was also a widespread fear that conflict might be renewed, with further losses of territory by the Greek Cypriots. The national economy of the unoccupied 64 per cent of Cyprus, helped by several externalities, proceeded to develop rapidly, and with the passing of the years the refugees were able to live with reasonable dignity. The state granted them the right to free health care, made subsidies to the costs of secondary education, and assisted with re-housing costs. Thus, although the refugees felt themselves to be victims of a huge injustice, they were better supported than is common in the conflicts which have arisen in the last 50 years. This factor will be important in the policy implications of our final argument.

Research Materials and Research Methods

Pre-history of the Study

The current study builds on data collected by the senior author in two earlier periods of research. Argaki village had been studied intensively between 1968 and 1972 combining qualitative and quantitative methods (Loizos 1975). These included a detailed survey of 200 male household heads, and a key-informant mini-survey of a further 100 households. These two surveys were concerned with land holdings, age of marriage, numbers of children, livelihood activities, and kinship relations. There was no health focus at that time, although qualitative health data were from time to time collected along with other social data during fieldwork. The general picture was of a rapidly developing farming community, in which 80 per cent of marriages were between people born in Argaki itself. At that time, the village birth register for the period 1920 to 1950 was laboriously copied with a view to later analysis. After the Argaki Greek Cypriots had been forced to migrate in August 1974, five months field research in the following year made a rapid assessment of their recent movements, their livelihood activities, and feelings of social and personal disorientation (Loizos 1981).

Study Design

For the present Two Village Health Study (TVHS) we decided to assess the health outcomes for men and women aged between 34 and 44 in August 1974, the moment of displacement for the Argaki villagers. This is a modification of what is known in epidemiology as a cohort study, where of two groups, one has been exposed to a specific risk, and the other has not, and a comparison of outcomes is made (Farmer *et al.* 1996: 16). The rationale for a focus on this age group was as follows: first, they were, with very few exceptions, married with dependent children in 1974. They accordingly faced a problem of providing for their children, and, in many cases, having to consider the future support of gradually ageing parents. The issue of provision for children has been culturally a high priority among Greek Cypriots. It is a dominant life goal for most people. In rural Cyprus in the 1970s, celibacy was shunned.

One assumption was that displacement had specific consequences according to where individuals were in the developmental cycle of the family/household. In Greek Cypriot society, men and women regard the key measure of their social success (or failure) in terms of having seen their children educated and married. On becoming a grandparent, and when all their children have married and had children in turn, senior men and women feel they can 'sit down and breathe' and consider issues of religion and the afterlife. The social obligation of young, unmarried people is to make their way in the world as energetically and independently as possible. Thus, by studying those who were burdened with demanding responsibilities, we would be more likely to see negative health consequences at their most intense. And since onset of many life-threatening conditions is age-specific, a narrow focus on a single cohort in late middle age might bring issues of 'early onset' into sharper relief.

Birth Registers

The birth register for 1930–1940 for Argaki village was already available to the study. We then obtained the birth register for the same period for the nearest non-refugee village to Argaki, the village of Astromeritis. In population, this village had been a little smaller than Argaki in the late nineteenth century, and it was probably not developing as rapidly as Argaki in the pre-conflict period 1960 to 1974. Nevertheless, it had been only three miles away from Argaki, in a similar ecological environment of irrigated plains agriculture, with good road access to the city of Nicosia. The occupational profiles were similar. Neither village was involved in notably dangerous productive activity such as asbestos mining, or industry employing chemical pollutants, which might have notably distorting health effects. The hazards associated with agricultural pesticides would be common to both villages.

For the TVHS we interviewed all the men and women we could find who were born between 1 January 1930 and 31 December 1940, an eleven year cohort. (The mean age for refugees was 68.09 and for non-refugees 68.61.) For the fifteen years prior to 1945 both villages had suffered high rates of infant and child mortality: typhus and tuberculosis had been prevalent, and access to modern medicine had been poor. It had also been a period of economic depression. We worked with key informants to remove from our birth register those known to or thought to have died in childhood. We then removed anyone from Argaki village who had migrated from it prior to 1974, but in order to obtain sufficient numbers for the smaller control village, we included a small number of Astromeritis villagers who had migrated prior to 1974. This left us with two sets of people whose major difference was that the refugees had been displaced and made destitute in 1974, and that the people of the non-refugee control village had in the main continued to reside in their community, and had not been forced to migrate in 1974. Those who had subsequently migrated after 1974, if they were still in Cyprus, were sought out for interview. We have interviewed 80 per cent of the eligible refugee cohort, and 85 per cent of the eligible non-refugees.

Our interest in premature death between 1974 and 2004 meant that we tried to trace everyone on the birth register (1930–1940) from either community who had died after August 1974. When we identified such a person, we sought information from next of kin, on the age and causes of death of their deceased relative.

Electoral Registers

Identification of the non-refugees was relatively straightforward. Most of them lived in a single compact village, and with the help of the birth register and the guidance of the village ‘mayor’ they were contacted on a house to house basis. The refugees were dispersed in many places, but their residence was ascertained by means of the electoral register, which groups all the persons from a pre-1974 community in a continuous series, wherever they are resident in the island. The ‘Argaki electoral register’ has 50 consecutive computer print-out pages with the following information:

1. electoral register number
2. identity card number
3. surname and first name
4. current street address
5. date of birth
6. ethnicity
7. father’s surname and first name
8. current suburb/village of residence.

We were interested only in those born between 1930 and 1940, and these were identified and highlighted in coloured ink by several systematic examinations of the register.

Telephone Directories

Once the persons on the birth register had been cross-identified on the electoral register (not as easy as it sounds) they could then be further located and contacted by means of the telephone directories for the island, and interviews set up. Telephone usage is near universal in Cyprus today, so there was no serious problem of failing to find persons on the electoral register. But of course, both electoral registers and telephone directories go out of date as people move, or die. We also found that for the village of Argaki, there were living persons not recorded on the birth register but who had nevertheless been born within the study period. They were added, and were few in number.

The basic demographics of the study are as follows:

Female non refugee	61	Female Refugee	70
Male non refugee	43	Male Refugee	80
Total	104		150

Male refugees are, then somewhat over-represented, and this may have a bearing on some data and analyses which follow.

Results

Table 1 shows the *reported* mortality for the two villages in the period September 1974 to December 2004. (These reports were not supported by any medical or coroner’s records. They are from next of kin.) Chi Square test

Table 1

Mortality 1930–1940 birth cohort, for the period 1974–2004				
Mortality*	Refugee Village		Non-Refugee Village	
	Count	% Cases	Count	% Cases
Base number	150	100.0%	104	100.0%
Cardiac	6	4.0%	7	6.7%
Cancers	6	4.0%	4	3.8%
Diabetes	3	2.0%	0	0.0%
Other	8	5.3%	5	4.8%
Total Cases	20	13.3%	16	15.4%
Total Causes Reported	23	1.15 per person	16	1.00 per person

*Some persons reported multiple causes of death.

shows no marked or statistically significant difference between the two villages, either in proportions, or in causes of death. It is possible that in the percentage of the birth cohort for whom we were unable to obtain information (20 per cent of the refugees, and 15 per cent of the non-refugees) there might be important differences. But a small number of ‘missing’ refugee deaths—e.g. 2, 3 or 4 persons—would not significantly alter the statistical significance picture.

Table 2 shows reported morbidity for the refugee and non-refugee cohorts. These data refer only to *living informants* interviewed in 2004. (Birth Cohort members who died between 1974 and 2003 were dealt with in Table 1.) Once again, we are dealing with informants’ reports of their illness perceptions, and not with confirmed medical diagnoses (Murray and Chen 1992). It is therefore essential to say something about how we classified informant responses.

The classification ‘major cardiovascular illness’ was reserved for individuals who had reported an incapacitating stroke or heart attack episode, and/or a surgical procedure arising from cardiac illness, such as valve replacement, a bypass, or balloon angioplasty.

The classification of ‘medium cardiovascular illness’ was employed when an informant had reported having elevated blood pressure for three or more years and had been placed on a regime of medication to control this. A reported stroke, particularly if it had caused lesser impairments, was also included in this category.

We did not include reports of occasional arrhythmias, or transient tachycardia, or brief episodes of elevated blood pressure. Such reports have been treated as sub-clinical and not classified. We may have underestimated the seriousness of some ‘minor’ conditions, and over-estimated the seriousness of

Table 2

Reported Morbidity by 1 October 2004 of the 1930–1940 birth cohort

Morbidity*	Refugee Village		Non-Refugee Village	
	Count	% Cases	Count	% Cases
Base number	151	100.0%	104	100.0%
Major Cardiac	19	12.7%	8	7.7%
Medium Cardiac	24	16.0%	14	13.5%
Cancers	9	6.0	1	1.0%
Diabetes	8	5.3%	9	8.7%
Dementia	3	2.0%	0	0.0%
Depression	8	5.3	0	0.0%
Total Cases	61	40.7%	25	24.0%
Total Diseases Reported	72	1.18 per person	32	1.28 per person

*Some persons reported multiple diseases.

some 'major' ones. For example, tachycardia and arrhythmia may be produced by drinking several cups of strong coffee in a short time. But they may also indicate more serious issues. It would require clinical knowledge and diagnostic tests to have greater confidence in these classifications. But if we have erred, it is most likely in the direction of under-reporting these conditions.

The data, when subjected to statistical analysis, show that the refugees report more major and medium cardiac illness than the non-refugees. The major cardiac illness finding has an 85 per cent probability of not being a chance association, and of being reflected in the wider population, and the medium cardiac illness finding has a 65 per cent probability. Both fall short of the 95 per cent level which would have constituted formal statistical significance. However, we found additional support for the suggestion that the refugees in our 1930–1940 birth cohort, now aged 64 to 74, have a higher risk of cardiac illness from the findings of a major epidemiological study of diabetes prevalence carried out in Cyprus 2003–2004, the DHyDO study (Loizou *et al.* 2006). The senior author had been asked to look at the social indicators for this study in the planning stage. Since diabetes is often associated with cardiac illness, and the study planned to carry out a number of checks for warning signs of both conditions, as well as take medical histories, we encouraged the investigators to include refugee/non-refugee status as one of a number of status questions. Data from this study analysed at our request showed differences between refugees and non-refugees in the relevant age groups in prevalence of myocardial infarction, angina pectoris, and blood pressure (Table 3). Figures 1–3 reproduced below, by permission of the medical statistician Dr. Stavros Pouloukkas, are relevant here. The reader is advised that these data, like our own data, must be treated as suggestive only; they are a by-product of a specialist study, and the numbers in the cells are relatively small. The national sample was of 1,200 persons aged 15 to 80.

Table 3 gives support to the findings of the Two Village Health Study: myocardial infarction shows nearly double the difference for refugees born in 1945–1949, somewhat lower for those born 1940–1944.

Because of our general interest in the length of the comparative working life, we asked for age of retirement and our data suggests 29 per cent of the refugees were continuing to work in 2004, as opposed to 11 per cent of the non-refugees. This difference is statistically significant (point probability 0.004).

Four Complementary Case Histories

We wish to briefly consider some qualitative material, which will help put the numerical findings in a better anthropological perspective. We note that medicine has always taken the case history seriously, and that serious medical journals are increasingly hospitable to qualitative data. The first three cases are of refugees affected by serious ill-health. The fourth case is of

Figure 1

Myocardial infarction: refugees and non-refugees

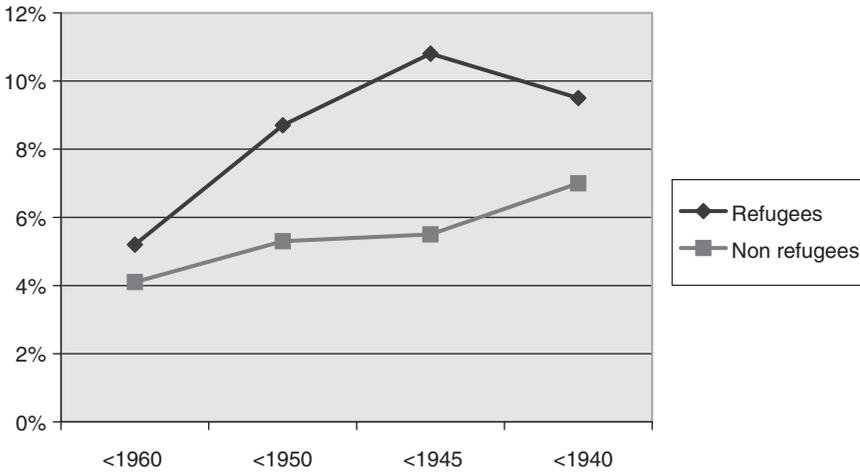
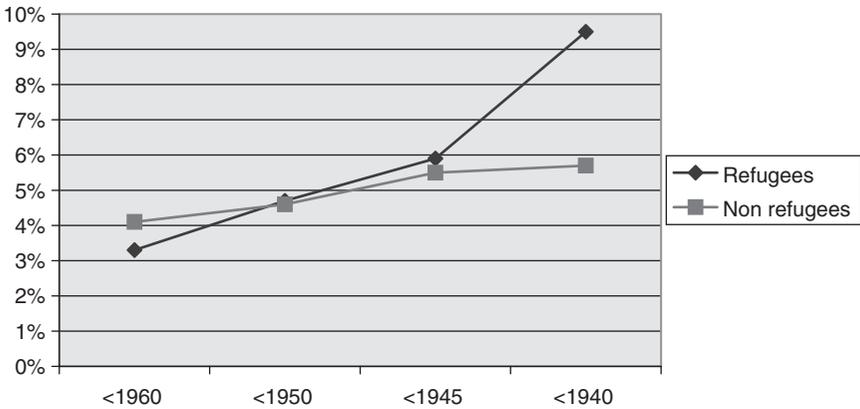


Figure 2

Angina: refugees and non-refugees



refugee well-being. The cases are all derived from interviews in the Two Village Study, supplemented with materials from earlier periods of study. Where informants wished to expand on the interview questions, they were encouraged to do so.

Figure 3

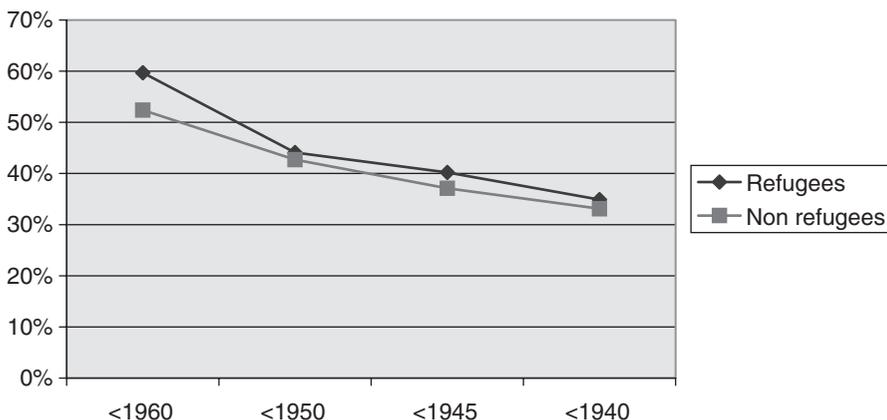
High blood pressure: refugees and non-refugees

Table 3

Evidence from the DhyDO study (Loizou *et al.* 2006)

Selected medical conditions for refugees and non-refugees, by date of birth. For each year, the first column refers to refugees, the second to non-refugees.

	Born <1960		Born <1950		Born <1945		Born <1940	
Medical Condition	<i>p</i> ₁	<i>p</i> ₂						
Myocardial infarction	5.2%	4.1%	8.7%	5.3%	10.8%	5.5%	9.5%	7.0%
Angina	3.3%	4.1%	4.7%	4.6%	5.9%	5.5%	9.5%	5.7%
High blood pressure	59.7%	52.4%	44.1%	42.7%	40.2%	37.1%	34.9%	33.1%

Case 1

Kallinikos (TVHS no 7) was born in Argaki village in 1938 into a poor family, was adopted as a child, and grew up in a farming family. He became employed as a delivery driver which he was able to combine with a small landholding. He became a refugee in August 1974, a father with two small children. For a time his family was housed in a garage in Nicosia. In 1981, when his daughter was starting to concern herself with future university education, which would have involved the family in substantial expenses, he had a major heart attack, which he survived. He was 43 years of age. He has not worked since then, but nevertheless suffered a stroke in 2001, from which he made a good recovery.

Case 2

Odysseos (TVHS no 2) was born in Argaki in 1932. He was from a poor family, but very determined to better himself. He worked as an agricultural labourer, later as an employee of the Department of Agriculture. He became a refugee in August 1974. For a number of years he, his wife and children were living in a draughty shack on urban land owned by his employer. The couple worked and saved hard. His daughter was able to study in the USSR. She returned with professional qualifications, and a husband from a poor country who although professionally qualified has been employed in a job lower than his skills and on only a modest salary. The young couple are now housed in a modern house in a suburb of Nicosia, and Odysseos and his wife live in a basement flat joined to this house. He cultivates vegetables on a piece of unused land adjacent to the house. At the age of 60, in 1992, he started to experience unexpected tiredness, was diagnosed as having blocked arteries, and a cardiac operation was performed using a vein from his leg to assist his heart.

Case 3

Androulla (TVHS no 3) was born in Argaki in 1934. She came from a poor family. She married a hard-working man from an equally poor family. Until becoming refugees, they worked on their small landholding, and he worked as a heavy machine driver. They had a son of 17 and a daughter of 13 in 1974 when they became refugees, and they lived in several mountain villages in temporary accommodation, but after several years received government assistance to build a small house in a refugee settlement, in a village 20 miles from the capital. This move was important because it made the daughter's secondary education easier. Androulla worked at first in a factory, then took a job ironing clothes, later worked as a cleaner in a secondary school. Her son graduated from a university in Canada, and now has a job as an accountant. Her daughter qualified in law, and works in a law office, but remains unmarried, aged 43 in 2004, a matter which in Cypriot society is emotionally difficult for a parent to deal with. Androulla's husband works six days a week at the age of 70 as a machine driver. Androulla started to feel tired in 1996 or 1997, and in 1998 (aged 64) had a heart valve replacement operation. She remains understandably apprehensive about her future health.

Case 4

Susanna (TVHS no 24) born in Argaki in 1937. From a small farming family, married a carpenter. They had six children aged from 14 to one year old when they became refugees. She says 'Being displaced set us back a great deal, but I faced it with patience and endurance.' She has had no significant health problems that she reports, beyond blood pressure having been raised for a period of three months some years ago. She worked as a seamstress for

the first 12 years of displacement. All six of her children have completed secondary education, and four have university degrees. This case has been mentioned to contrast to the previous ones—an example of successful coping with no major reported health problems, where perhaps the children and their success in education have acted as ‘protective factors’.

Discussion

Mortality

The TVHS data did not support the belief among Argaki refugees that ‘the refugees have been dying earlier’. Since they have not been conducting surveys, there is no reason why they should as individuals have reached a correct conclusion. It will take a national sample to see if our findings for two villages apply more generally, and this research is under consideration. But whether such a study supports our micro-data or not, one interesting anthropological question is, why are the Argaki refugees predisposed to think as they do—to believe that they are dying ‘earlier’ than non-refugees?

We can offer the following tentative suggestion. The Greek refugees in Cyprus have a well-documented tendency to describe their lost communities in very positive terms, and often refer to their way of life pre-conflict as ‘paradise’ (Zetter 1998; Hadjiyanni 2002). This Christian biblical framing of experience tends to make them see the post-1974 expulsion from ‘paradise’ as a ‘protracted exile’ in Zetter’s resonant phrase, but also, we suggest, there is a tendency to map all unpleasant events onto the condition of exile, and premature death is normally the most unpleasant of all life events. Lives have in some profound sense divided into Before and After. Before, things were Good; After, things have been Not-Good. The 1930–1940 birth cohort were men and women in their prime in 1974, with typically little personal experience of the premature deaths of close relatives. Over the following 30 years, their own biological ageing has been intensified by the additional hard work needed to re-build their livelihoods (evidence supporting this was just cited) and when some of their fellow villagers have died there may have been a tendency to perceive the deaths as ‘due to’ the refugee condition, rather than deaths which might have occurred at the same age anyway because of the particular heredity of the individual in question, and the kinds of health-specific actions—diet, exercise, smoking, alcohol consumption and work activities—they were affected by. To push the argument a little further: just as in some African societies, all human deaths have been attributed to ‘witchcraft’, so among the refugees, there is a tendency to attribute death to ‘the refugee condition’ (*proshygia*) and ‘stress’ (*angkos*). We do not suggest that the refugees are deeply resistant to more rationalist bio-medical arguments, if they are offered them, for they are a health-conscious group of people, with all the means–end rationality of effective farmers and small business

entrepreneurs. It is rather that when the disturbing fact of human mortality—the loss of friends or relatives—comes up in chance conversations, their *explanation of first recourse* is to point to the stresses of refugee life. It is consistent with other aspects of their cognitive-affective outlooks.

Cardiovascular Illness

Our data suggested that refugees might be more likely to have cardiovascular illness, but this remained suggestive, rather than conclusive. If it is indeed the case, it would not be surprising to cardiologists. But why might it be the case? We cited Appels and Mulder (1988) earlier on feelings of ‘excessive fatigue’—often early warning signs of cardiac problems. Because a range of different conditions can produce feelings of ‘excessive fatigue,’ rather sophisticated studies would be required to filter out key factors. Certainly, refugees in Cyprus have had in the words of Appels and Mulder ‘a long-standing problem they have not been able to solve’, and ‘have experienced both real and symbolic losses’ (1988: 762), factors flagged up by earlier researchers as accompanying ‘excessive fatigue’ reports. Other studies suggest that persons who experience anger intensely and frequently are more prone to cardiovascular 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.

Some of our survey data related to the question of the length of the working life, and for the refugees this might also contribute to feelings of excessive fatigue. As the refugees were made destitute in 1974, and the non-refugees had not had this experience, we attempted to see if in later years refugees were continuing to work longer, after the non-refugees had stopped. In refugee narratives of how they coped with destitution they frequently referred to working long hours, or holding down second jobs.

Dislocation and destitution would, we suppose, be experienced, at least for the initial years before economic recovery was starting to seem plausible, as the sense of ‘lack of control over workplace conditions’, if not a loss of control over their whole lives. That would be consistent with other studies cited earlier.

Greek Cypriot refugees in Cyprus have enjoyed a right to free medical testing, in public health clinics. They routinely have tests for blood cholesterol levels, for sugar levels indicative of diabetes, and for other indicators. The non-refugees do not collectively have such an entitlement, unless they are civil servants. In our control village, relatively few of the respondents were civil servants. It is possible that refugees have made more use of precautionary diagnostic tests, and that this allows them to monitor their health in ways which reduce the likelihood of some illnesses, and allow early treatment. Perhaps the refugees’ perception of their own vulnerability encourages them to greater self-care than the control group.

Psychological Illness

Few of our refugee informants had lost a close relative in the 1974 conflict. Six violent deaths were noted for 1974, in a community which numbered 350 nuclear families. We decided not to ask PTSD-oriented questions, so we cannot comment on whether or not Argaki refugees would (if they had been asked eliciting questions) have reported behaviours which fit a PTSD diagnostic schedule. We noted earlier that the Argaki refugees attribute some health difficulties to '*angkos*'—'stress'.

So although our primary concern was originally with cardiovascular illness, we also obtained data on reported mental illness, particularly depression, because we asked informants to mention all incapacitating illnesses, and we prompted them with the Greek word for depression, *thlipsis*, explaining it as an emotional condition which left a person very sad, unable to work, and needing medical help. The refugee villagers had been familiar with the outward signs of the condition, as there had been at least two men in the village prior to displacement known to have long-standing and medically-confirmed depressive conditions. In responding to this prompt question, informants usually reported much unhappiness when they first became refugees, using such Greek words as *marazi* (grief, sadness), but insisted that they had had 'too much to do' for clinical depression to take hold of them. Women, particularly, mentioned the number of children they had had to care for. Depression is understood by Greek Cypriots today to be an illness, and not a character defect, or an affliction related to evil-doing or sin.

No attempt was made to administer the sophisticated instruments used by psychologists assessing psychological illness clinically. Nevertheless we think our findings worth reporting. Among the 150 Argaki refugees, we logged three cases of reported depression, two men, one woman, of which two clearly had had pre-war onset, and two additional cases of men who apparently drank themselves to death, a process which had been accompanied by depression, cardiovascular illness and diabetes. There was another diabetic male with incipient alcoholism in the survey. There were two people, a married couple who had lost a child unexpectedly through leukaemia, who 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.' Another refugee had an episode of manic-depressive illness before he was displaced, but no recurrence after displacement. As our question asked about serious illness over the lifetime, this person was included, even though the illness is clearly not displacement-induced. The total for the refugees if this individual and the couple mentioned earlier are included is eight persons. In the control village, we were informed of no cases of depression among living respondents, although numerous respondents reported themselves suffering 'stress'. One man had died in a psychiatric hospital of unknown causes. However, there is some

Table 4

Reported Significant Illness over Lifetime, for the 1930–1940 Birth Cohort

Morbidity	Refugee Village		Non-Refugee Village	
	Count	% Cases	Count	% Cases
Living persons only				
Base number	129	100.0%	92	100.0%
0	35	27.0%	15	16.3%
1	59	45.7%	26	28.2%
2	26	20.1%	30	32.6%
3	8	6.2%	11	11.9%
4	1	0.8%	8	8.7%
5	1	0.8%	2	2.1%
Totals	129	100.6%	92	99.8%

Excluded: appendectomy; tonsillectomy; short-term raised blood pressure (under one year).

Included: raised blood pressure with medication, for several years. Medication for 'stress'; typhus in childhood; any cancer episode even if 'cured'; arthritic conditions requiring medication or surgery.

stigma attached to psychological illness, and as the researcher on the non-refugee village was not well known to the respondents, it is possible they were less willing to disclose vulnerabilities to him. To conclude: the refugees reported depressive illness significantly more than the non-refugees (point probability 0.005).

If we add together all reported serious illness—cardiovascular, cancers, diabetes, depressions—then the refugees reported significantly more serious illness than non-refugees (point probability 0.01 level) (Table 4). But paradoxically, more non-refugees reported more lifetime illnesses overall than refugees, and more refugees reported no lifetime illness, or few illnesses in their lives. That is consistent with some other studies in which it is the demographically healthier population which reports more illness (Murray and Chen 1994).

Coping with Displacement

Grievance and Transcendence

Argaki Greek Cypriot refugees spoke about having been brought low through loss of their properties. They see themselves as people for whose human rights the world no longer cares, and have a strong sense of grievance and victimhood. But also, they take pride in having spiritually and politically transcended dislocation. If we compare them to the Latvians discussed by Skultans (1996) most Argaki refugees experienced nothing as terrifying as the Baltic upheavals. They experienced a short, deeply unsettling upheaval, a period of intense uncertainty and fear, with specific losses—of property

and of *communitas*—and they were later able to take a relatively predictable, slow, hard-working road to economic and social recovery. Their ‘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 that they had had ‘strong souls’.

Discussing severe life events and physical illness, Creed stated the problem which has re-surfaced in another form more recently in refugee studies:

Since the severe life event seems to have an apparently identical impact on many people, the most striking feature is the variability in response—why do some people appear able to withstand such stress without illness while others die?

The answer will be a complex set of physical and psychological variables that life-events researchers must eventually be able to define (Creed 1985: 114).

When we started this study, we had expected that the data would strongly support the hypothesis that refugees were dying ‘earlier’ than non-refugees, and that cardiovascular disease rates would be markedly higher among the refugees. This seemed a reasonable inference from the literature on psychosocial stress (e.g. Clark *et al.* 1995; Marmot and Bobak 2000; Appels and Mulder 1988; Marmot *et al.* 2000). We cannot pretend to be working to equivalent levels of rigour. But on the evidence so far, it looks as if the story we need to tell is about a refugee population who are managing their health rather better than the literature on psycho-social stress would have led us to expect. Accordingly, we turn our attention to this issue.

Protective Factors in the Greek Cypriot Case

Ahearn’s edited volume *Psychosocial Wellness of Refugees* makes an important point in its title and introduction: most refugees cope, survive, act purposefully and effectively. In our study, refugees have not died in larger numbers or ‘earlier’ than non-refugees, and although somewhat more have experienced serious cardiac illness, they have survived it so far. 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. This follows up on important early work by Kinkle and others (1974) on the major differences in how groups of people deal with challenges to health.

So, what protects Greek Cypriot refugees, by definition subjected to a severe life event, from more illness? Why do so many of them retain both agency and meaning in their lives?

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

If we compare the Cyprus case with the Eastern European post-socialist states 1989–1995 (Cornia and Paniccia 2000) and the ‘demographic shocks’ they experienced (Eberstadt 1994; Marmot and Bobak 2000; McKevitt *et al.* 2003) we can point to ‘protective factors’, for reasons why people who were dislocated, do not have higher mortality, or do not report dramatically more major health difficulties. The following three reasons are proposed:

- They were received into a sympathetic state and society of co-ethnics, co-religionists, which also made available significant resources. This state achieved a remarkable economic recovery within a relatively short space of time (Strong 1999; Zetter 1992, 1998) partly by harnessing refugee labour productively, partly by supporting refugee self-help efforts with favourable economic and social policies.
- The refugees’ pre-dislocation life goals—educating their children and seeing these children marry—remained meaningful and attainable (Colson 1981; Hirschon 1989; Loizos 2000). Given a slow reduction in completed family size and generally positive economic growth, these goals remained within the practical reach of the 1930–1940 cohort. Adherence to those pre-displacement goals allowed people who exerted themselves to rebuild their livelihoods to keep their self-respect as adults, and to keep coherence in their lives. They were ‘locked into’ sustaining life projects and trajectories. They had to keep well, physically and mentally, to produce a virtuous circle.
- Their life-goals are specific, but also general and flexible enough to accommodate individuals’ relative shortfalls. 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 expensive tertiary education. If a child marries somewhat later, or with a mortgage rather than a paid-off house, this can still be counted as ‘success’.

Wider Implications

There are numerous studies of refugee and migrant health in Canada, the USA, Australia and Europe (Council of Europe 2000; Eastmond 2000; Kliever and Jones 1999; Powles 1997). Many of these studies record cultural definitions of health perceptions, or 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 by crossing international state borders will often have to: use a new language; live in an unfamiliar society; face labour market disadvantage/discrimination/downward mobility; face forms of racism and

denials of their legitimacy. Of these four factors, only the third operated for Greek Cypriot refugees.

Agamben's complex argument ends *Homo Sacer* (1998) with refugees who are treated as persons without rights, an argument already made by Hannah Arendt as early as 1951. It clearly applies to many situations facing refugees today. One argument of this paper is that the Greek Cypriot state did *not* treat the Greek Cypriots displaced in 1974 as people to be disregarded, kept in camps, or otherwise marginalized and humiliated. It did not give them what Agamben terms *la vita nuda*, awkwardly rendered as 'bare life', better as 'a meagre existence'. It respected 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 even a well-supported refugee is an increased risk of cardiovascular disease, and serious illness more generally, the risks for refugees in 'failing states' and poorer, larger countries may be very much greater. That is why we hope others will follow up on these suggestions.

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