Refugees, torture victims, or “ethnically cleansed” persons – both young and old – differ from military war survivors by their status as nonparticipants in military operations. Chapters in this section detail some of the important research about epidemiological and developmental aspects of and relationships between sleep and post-traumatic stress disorder (PTSD) in these populations. There is currently a remarkable lack of mapping of trauma exposure on pathological phenotypes or endophenotypes. So, are there “special” features about these groups that might inform the field to advance knowledge and interventions, and if so, what are they? Combatants and civilians both experience severe stress and traumatic events during war that are associated to some degree with distressing symptoms, illness, and impairments. Among these symptoms are poor sleep and bad dreams. Perhaps the answer to the question lies outside of what is usually measured. Culture-bound constructs, such as “PTSD,” “mental health,” and “physical symptoms,” might limit what we can find. The British-Hungarian scientist-philosopher Michael Polanyi argued that positivism supplies a false sense of knowing, because epistemology always involves personal and cultural commitments. Polanyi aligned with Aristotle who believed that “the whole is greater than the sum of the parts,” by concluding that “we believe more than we can prove” and “we know more than we can say.” Empirical methods bring us great information and simultaneously are a lens through which facts are sometimes limited more than expanded, distorted more than clarified.

Refugees of war displaced to the USA are said to have experienced between 3 and 19 traumatic events when using standard instruments designed by expert consensus methods. These events have been described as psychological, physical, or sexual types. Yet, when a similar group of refugees are included in the research process using mixed methods, we find that there are over 250 traumatic events to which they as a group have been exposed, and each person on average experienced 150 events. Looking in more detail, this breadth and depth of experiences factored into 12 event types instead of 3, a few of which, such as forms of deprivation/discrimination, displacement, separation/isolation, and difficulties during migration, are not in the common quantitative literature about war survivors. It is no surprise that strength of association between events and any measure of health is larger when using a broader – rather than a narrower – range of events. These types of experiences also extend from early wartime, through migration and displacement, and into resettlement in a new “home.” Displacement, for example, is a variable that has not found its way into a mainstream research, while key studies detail the pathogenic effects of it. Dimensions of place define the immediate environment outside of
the person. Place facilitates attachment, development and identity, and survival. Disruptions to place threaten biopsychosocial homeostasis by altering attachments, familiarity, and place identity and result in psychological problems of nostalgia, disorientation, and alienation. Place loss affects people’s sense of identity and belonging and is an identified risk factor for poor health. One could hypothesize that displacement affects sleep, either directly or mediated through stress chronicity and/or resettlement factors that impair identity formation and meaning.

Likewise, common instruments that assess symptoms or health status in civilian war survivors have been developed by expert consensus methods, usually having between 9 and 30 items that most often assess single disorders that are either “physical” or “mental.” When refugees are included in the research using mixed methods, 121 possible chronic symptoms were identified, with the average person experiencing 48 (SD 31, range 0–118) of them. Further evaluation found 12 symptom types, 9 of which are somatic and 2 psychological. Symptoms of depression and PTSD factor together, except for a factor termed “PTSD vulnerability,” which consists of seven symptoms regarding a lack of emotional feelings for others and thinking that traumatic events are going to occur again. The overall correlation between war-trauma scores and symptoms was 0.47, which is nearly double the correlation using common instruments. Looking at individual symptom scales, six of the nine somatic scales correlated just as highly with trauma as did the anxiety and PTSD/depression scales (range 0.35–0.42). The fact is most war survivors experience a myriad of symptoms throughout the body, all of which are related to trauma due to profound effects on multiple biological systems. Cambodians displaced to the USA have a two- to threefold higher number of medical/psychiatric disorders decades after migration compared to the general US population. The narrower the health construct, the smaller the associations between health and trauma. And while war-related trauma is a significant predictor of symptoms, other prewar, migrational, and post-migrational experiences explain a large part of the variance of symptoms and disorders.

Perhaps special features of civilian war survivors are features of all war survivors: effects of war are deep and broad and defy easy categorization. Research regarding trauma and health outcomes lacks adequate assessment about constructs that matter, which allow us to find valid associations and make valid conclusions. The whole is greater than the sum of the parts. We believe more than we can prove. Exposure to the almost uncountable stressors during war, in the context of being an unwilling participant, has effects that are difficult to measure. Losses are profound. How do we measure the effect of world loss and soul loss on sleep? Is it abnormal to not sleep where one does not belong, where one was told by collective action that one should not exist? Perhaps we need to focus the lens differently in order to view more of the whole.