Mental health in war-affected populations
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Chapter 1

Introduction
1. Introduction

Collective violence occurs on a daily basis in many parts of the world. It may be defined as the instrumental use of violence by people who identify themselves as members of a group—whether this group is transitory or has a more permanent identity—against another group or set of individuals, in order to achieve political, economic or social objectives. It can take various forms, including war, terrorism or other violent political conflict within or between states; state-perpetrated violence such as genocide, repression, disappearances, torture and other human rights abuses; organized violent crime such as banditry and gang warfare. The impact of violent conflict on health can be very great in terms of mortality, morbidity and disability.

This thesis presents a set of research projects relating to populations residing in low-income countries recently affected by collective violence, or in refugees camps close by. Over the course of time during which our studies took place, theory and insights developed. There was a substantial increase of knowledge with respect to prevailing mental health and psychosocial problems in war-affected nonwestern populations, and a significant change in views on approaches to help mitigate these problems. Undeniably, this thesis represents these developments, and therefore may also be read as an account of this history. Its final chapter will discuss the development of views over time and the practical implications of our findings.

Overall study objectives

The overall objectives of the studies presented in this thesis were:
- to assess the mental health condition of populations affected by collective violence;
- to establish the adequacy of large-scale psychosocial interventions for such populations, aiming at social reintegration.

Mental health consequences

Mental health problems

The violence and cruelty of armed conflict is associated with a range of psychological and behavioural problems. In 2001, the World Health Organization (WHO) stated that ‘in situations of armed conflict throughout the world, the most common conditions were depression, anxiety and psychosomatic problems such as insomnia, or back and stomach aches.’ Up to some years ago, the number of epidemiological studies addressing the mental health of
populations living in nonwestern postconflict areas at the community level was limited. Out of the community-level mental health surveys among war-affected populations published in the 1990s and early 2000s, three addressed survivors of the ex-Yugoslavia wars that raged in the 1990s. Two others presented combined data from four groundbreaking, interrelated studies by De Jong and colleagues, conducted in Algeria, Cambodia, Ethiopia, and Gaza. Prevalence rates of assessed posttraumatic stress disorder (PTSD) found in these postconflict settings were 37.4%, 28.4%, 15.8%, and 17.8%, respectively. Rates of mood disorders varied from 5.8% to 23.3%; rates of anxiety disorders from 11.3% to 42.3%, rates of somatoform disorders from 1.6% to 8.7%, and rates of any common mental health disorder from 27.8% to 62.3%. The researchers particularly pointed to the different determinants that symptoms of PTSD can have in different populations affected by mass violence, and to the high prevalence rates of mental disorders other than PTSD related to armed-conflict-associated violence. A review in 2007 of epidemiological findings relating to war-affected populations across Africa, the Middle East, and Southeast Asia showed a variety of syndromes like PTSD, depression, complicated bereavement reactions, substance abuse disorders, anxiety, somatisation, disturbed anger control, and functional disability. A later review and meta-analysis of data from 81,866 refugees and other conflict-affected persons from 40 countries focused on PTSD and depression in particular, as these disorders are the most prevalent in such populations. Due to varying methodological characteristics of the surveys included, the interstudy variances were substantial. Rates of reported PTSD varied between 0% and 99%; depression rates varied between 3% and 85.5%. Weighted prevalence estimates derived from a subset of methodologically robust surveys ranged between 13% and 25%.

**Psychosocial problems**

Results from the latter study also support the notion that broader ecological-social factors interact with personal exposure to trauma in shaping mental health responses. This is endorsed by a growing number of researchers and humanitarian aid experts, who stress that collective violence also affects individuals through the destruction of the social world which embodies their history, identity, and living values. As stated in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, mental health and psychosocial problems in war-affected populations are highly interconnected. Significant problems of a predominantly social nature include pre-existing social problems (e.g., extreme poverty, political oppression), and emergency-
induced social problems (e.g., disruption of social networks, family separation). Similarly, problems of a predominantly psychological nature include pre-existing problems (e.g., severe mental disorder), and emergency-induced problems (e.g., nonpathological distress; depression and anxiety disorders). Thus, psychological problems in populations affected by collective violence encompass far more than the experience of psychiatric disorder.

**Psychosocial interventions**

Findings as mentioned above may inform policies and strategies that focus on improving conditions in the recovery environment in mitigating the mental health effects of mass conflict and displacement. It is advocated that interventions should aim at strengthening community and family supports as well as providing focused support or specialized care, thereby bridging the divide between psychosocial and trauma-focused frameworks. Resilience in individuals may be promoted at a community level by reinforcing protective factors such as belongingness and intergroup relations, or the maintenance of traditions and cultures. Psychosocial support programs may comprise elements aiming at the mobilization of a community’s capacity for interpersonal support, activating family and social networks, supporting parenting programs, educational activities, or facilitating communal activities like singing, storytelling and religious worship.

**Social capital**

In strengthening community structures the notion of social capital seems to be relevant, as it relates to the re-establishment of social cohesion, social networks, and collective action. The more a social network is characterized by norms of trustworthiness and reciprocity, the greater the social capital it represents. Social capital then reflects the strengths by which people and groups are held together and which make cooperative action possible. While the relationship between social capital and health has been widely recognized, there are also clear indications that social capital is associated to mental health. This relation, however, seems to be more complex. The effects of social ties vary with gender, socioeconomic position, and stage in life. Also, individual networks, and therefore person-related social support and coping behaviour, are contingent on outer layers of ties like civic associations and voluntarism. Contextual factors seem to not only mediate the relationship between various components of social capital but also between these and health outcomes. The link between social capital and mental health may be relevant with regards to postconflict recovery, especially if social capital could be intentionally promoted.
Introduction

Study locations
Our studies were conducted at three different locations, notably: in a refugee camp in Tanzania, close to its northwestern border; in an eastern province of Afghanistan; and in a northern district of Rwanda. In effect, these studies relate to populations which reside in, or have fled from two countries, Rwanda and Afghanistan. Both countries have long histories of violence.

Rwanda was subsequently ruled by Germany and Belgium from 1894 to 1963. Both colonizing powers grossly classified its population along an ethnic divide between Tutsi and Hutu, while privileging the Tutsi. During a Hutu rebellion from 1956 to 1959, 100,000 people were killed. Tutsi refugees in Uganda formed their own party, the Rwandan Patriotic Front (RPF). In 1990, the armed wing of the RPF (the RPA) invaded northern Rwanda, which started off a civil war. A ceasefire in 1993 seemed to end the hostilities, but a genocidal period in 1994 killed 800,000 Tutsi and moderate Hutu. Subsequently, the RPA defeated the Hutu militias and took over control.

In Afghanistan, a communist coup in 1978 started off a period of mass arrests and tortures. During the Soviet occupation from 1979 to 1989, a fierce guerrilla was fought by and between Mujahedin entities. After the defeat of the Soviets, a civil war raged until the Taliban gained control over most of the country by the end of the 1990s. They settled a regime which was both oppressive and hostile to the western world. From 1999 onwards the United Nations imposed economic sanctions, and ultimately the USA attacked. In 2002 the Taliban was defeated, after which regional warlords regained control.

Specific study objectives
The overall study objectives mentioned earlier were pursued by establishing:
- the mental health condition of two populations which differed greatly with regards to geopolitical history, sociocultural background, and actual living conditions, notably: inhabitants of Afghanistan and Rwanda;
- the way prevalence estimates of mental health disorders may influence mental health policy or intervention programming;
- the feasibility and local adequacy of two psychosocial interventions primarily aiming at social reintegration of populations residing in completely different settings, shortly (refugee camps Tanzania) and more than 10 years (Rwanda) after collective violence;
- the possibility to validate an instrument for crosscultural use to assess the effect of a psychosocial intervention, while not focusing on separate psychiatric diagnostic categories;
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- the effect of community-based sociotherapy on mental health in northern Rwanda;
- the possible connections of social capital with mental health and its relevance for postconflict recovery.

**Chapters of this thesis**

This thesis contains two epidemiological studies, an instrument validation study, two intervention process descriptions, an intervention outcome study, and a theoretical review. The sequence of chapters of this thesis does not follow this division. Chapters have been grouped on the basis of logical coherence. The order of chapters also reflects the chronology of our studies, and thereby the development of relevant insights and knowledge over the intervening period.

**Epidemiological studies (Chapters 2 and 4)**

The objective of our first epidemiological study, presented in Chapter 2, was to establish the general mental health condition of a refugee camp population. It was conducted shortly after a period of massive violence in Rwanda. Médecins sans Frontières provided medical humanitarian emergency aid for the hundreds of thousands of refugees flowing into the camps that arose just across the border of the neighbouring countries, Tanzania and Zaire (now DR Congo). We assumed that many refugees suffered from psychological problems originating from a range of recent traumatic experiences and otherwise adverse events. At the time, however, little knowledge existed about prevalence rates of mental health needs in refugee communities. We identified nine studies on the subject, only four of which had been performed at community level.23-26 Only one of these had been conducted in a nonwestern setting; this study yielded rates of symptoms correlating with depression and PTSD of 55% and 15%, respectively, in Cambodians living in Thailand-Cambodia border camps.24 As there was a need for additional epidemiological data, we performed a survey among refugees from the atrocities in Rwanda residing in four camps in the northwestern part of Tanzania. Our study aimed to establish the mental health condition of the population; it therefore focused on the detection of psychiatric cases in general, instead of symptom rates of particular psychiatric disorders such as PTSD or depression.

Our second community-level epidemiological study was performed among survivors of war living in an open setting in Afghanistan (Chapter 4). This study was conducted in collaboration with the aid agency HealthNet International, which at the time ran a program aiming to help rehabilitate the health-care
system in the region in question. This time, our survey focused on symptoms of the specific psychiatric disorders which had been proven to be the most prevailing in postconflict contexts, notably: PTSD, depression and anxiety disorder.

*Intervention process descriptions (Chapters 3 and 5)*
In this thesis, changing insights also manifest themselves across the chapters addressing intervention models. At the time of the Rwanda crisis it was not self-evident that a mental health or psychosocial program for survivors of collective violence would primarily focus on social reintegration. The model which we piloted in refugee camps in Tanzania and Zaire (Chapter 3) did, however. It constituted a shift away from the trauma-focused approach which seemed to have become standard over the preceding years, and which was mainly modelled upon psychosocial programs for survivors of the wars in the ex-Yugoslavia region. Later, when we started implementing the community-based sociotherapy program in northern Rwanda (Chapter 5), intervention strategies with a scope beyond psychiatric disorders only, targeting communities rather than individuals and taking a public health or ecological approach, had become state-of-the-art in the eyes of many professionals in the field.

*An intervention outcome study (Chapters 6 and 7)*
While considering the implementation of the psychosocial intervention program in Rwanda mentioned above, we were aware that categorical mental disorders did not fully suit as indicators for prevailing psychological needs. Therefore, the program focused on the general population. No diagnostic entry criteria were used. All the same, we aimed to establish the effect of the intervention on mental health, and struggled to conduct a controlled study with a suitable and locally validated instrument. In accordance with the decision to refrain from defining diagnostic inclusion criteria, general mental health (instead of one or more specific diagnostic categories) was measured as intervention outcome.

*Social capital (Chapter 8)*
The attention for social reintegration in intervention programming naturally led to an interest in social capital. The relevance of the social capital construct for mental health in war-affected populations is discussed in Chapter 8 of this thesis, with the use of, among others, outcomes from our studies on the sociotherapy program in Rwanda as a reference.
References


