Mental health in war-affected populations

Scholte, W.F.

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Mental health in populations affected by collective violence

This thesis comprises research projects which were conducted in low-income, postconflict contexts. The first objective of our studies was to assess the mental health condition of populations affected by collective violence. To this end, we studied two populations which differed greatly with regards to geopolitical history, sociocultural background, and actual living situation. We also wanted to establish the way prevalence estimates of mental health disorders may influence mental health policy or intervention programming for the setting in question.

Epidemiological studies

We performed two epidemiological surveys. Both populations studied had been affected by collective violence, but otherwise had quite different histories, backgrounds and current conditions. The first study was conducted among Rwandan refugees living in refugee camps. A relatively limited period of extreme collective violence had happened recently, and the actual living conditions were unfamiliar, chaotic, harsh and insecure. The Afghan population studied in our second survey had experienced over 20 years of warfare, but the current situation was more or less stable, and families lived within their own compounds and communities.

Validity issues and findings

As our 1995 survey among Rwandan refugees in camps took place in a highly paranoid and politicized atmosphere, a condition to the instrument used was that it would be perceived as completely neutral, not referring to violence in the past. Also, it should allow for administration within a minimum of time, and language used needed to be very simple. We used the 28 items version of the General Health Questionnaire (GHQ-28), a screening instrument for mental ill health which does not focus on particular psychiatric disorders such as PTSD or depression. As the instrument had not been used in a Rwandan context before, we calculated its sensitivity and specificity for this particular population. The estimated sensitivity, specificity, positive and negative predictive values found for different GHQ-28 cutoff scores, indicated that a cutoff value of 14 was appropriate in this setting. Compared to the recommended score of 5 for use of the GHQ-28 in general populations, a value of 14 seems extremely high. This may relate especially to our case definition, which was more severe than usual with the GHQ-28, and to the extreme actual living conditions, causing baseline scores to be markedly high already. The way we validated the GHQ-28 for local use may
be considered exceptional, as meeting our case definition was not determined through a clinical assessment or the application of a gold standard. Instead, all members of the study population seeking support from our intervention program automatically qualified as cases. Findings of our survey suggested that 50% (SE 12%) of the refugee population suffered from serious mental health problems. In 2003, when we conducted our survey in Afghanistan, our moves were less restricted by security problems, and more time was available for interviewing. Also, various studies in low-income postconflict settings had shown by now that symptoms of PTSD, depression and anxiety were the most prevailing.\textsuperscript{2-6} We chose to use instruments screening for these specific diagnostic categories, notably the Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptom Checklist (HSCL-25). Our study yielded high reported symptom rates of depression (36.5%), anxiety (51.8%), and PTSD (20.4%). Prevalence rates were higher in women than in men, with odds ratios of 7.3, 12.8, and 5.8, respectively. These findings must be viewed while taking into consideration that we had failed to validate our instruments for local use. The publication of our study gave reason to an accompanying editorial in which, among other things, the authors addressed the relevance of local validation of instruments used in cross-cultural settings, as cutoff scores and clinical interpretation of findings may differ greatly between populations or contexts.\textsuperscript{7} Later, this was particularly confirmed for the Afghan cultural context by Ventevogel et al., who explored the validity of the HSCL-25 and the Self-Reporting Questionnaire (SRQ-20) locally. As was concluded, our survey may have overestimated the prevalence of mental disorders among women and underestimated the prevalence in men.\textsuperscript{8}

\textit{Relevance of findings}

Our findings in the Rwandan refugee camps suggesting massive psychological suffering, contributed substantially to the general awareness of the mental health needs of refugees. It added to the scientific evidence of the devastating impact of mass violence on mental health, and to recognition of the urgency to address mental health needs as part of emergency responses to refugee crises. The publication of our study prompted the then director-general of the World Health Organization to write an accompanying editorial, stressing the relevance of community-based psychosocial care as an integral part of emergency response and of the public health-care system in camps and national services.\textsuperscript{1} The strength of our study in Afghanistan became particularly manifest through one major implication: it helped convince the national authorities in Kabul of the magnitude of the country’s mental health problem. In the first declaration of the new minister of public health, 4 months after the simultaneous publication
of our survey and a comparable study by Lopes Cardozo, another mental health was nominated as one of the national health policy priorities. Another strength of the study was that our findings provided information on the main resources of emotional support of the population in question, thereby indicating the values and community structures which an intervention should aim to restore primarily. Today, it is generally known which mental health symptoms or disorders are highly prevalent in postconflict settings, and that these symptoms tend to persist long after the conflict has ended. The authors of the abovementioned editorial in *JAMA*, however, questioned the relevance of data produced by this kind of epidemiological research. Indeed, by 2004 there was growing awareness that symptoms reported in postconflict settings might represent distress stemming from environmental instability rather than psychopathology. Therefore, prevalence rates might only have clinical significance if associated with functional impairment. All the same, the number of mental health professionals in low-income settings would far from suffice to provide adequate support to all persons at risk of mental disorder. For these reasons, it can be assumed that prevalence rates of mental health symptoms do not suffice to reflect the psychosocial needs of those that have experienced life-threatening events, displacement and the collapse of their communities. Neither do they inform us about the most suitable and feasible ways to offer support in the prevailing circumstances.

However, epidemiological data may still be valuable for informing postconflict mental health policies or intervention programs, if associated with a disability assessment and an identification of current stressors, mental health and psychosocial problems and needs, and protective factors from the perspective of the affected population, and with data on the cost effectiveness of a possible policy or program. For the sake of validity, mental health assessments should preferably be conducted using culturally grounded measures. The relevance of most of these conditions is illustrated through developments and findings after our Afghanistan study took place: 1) Miller and colleagues showed the validity of a locally developed 22-item instrument (the ASCL) to identify indicators of distress in Afghanistan. The ASCL comprises several indigenous items and items familiar to Western mental health professionals. Although the researchers found scientific support for the validity of the PTSD-construct in this context, both depression and general distress as measured by use of this ASCL correlated more highly with war-related traumatic stress than did PTSD. 2) Another study in Afghanistan, performed by the same group, compared the role of war experiences with daily stressors as predictors or moderators of mental health outcomes and functional impairment. They found convincing evidence
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for a major role of daily stressors. The donor community appeared to be very reluctant to provide sufficient financial funding for the intended mental health policy in Afghanistan, because data on the cost effectiveness of public mental health interventions were not available.

**Psychosocial interventions aiming at social reintegration**

The second objective of our studies was to establish the adequacy of large-scale psychosocial interventions for populations affected by collective violence, aiming at social reintegration. To this end, we studied two psychosocial interventions primarily aiming at social reintegration, targeting populations residing in completely different settings, shortly (refugee camps in Tanzania and Zaire) and more than 10 years (an open setting in Rwanda) after collective violence, respectively. We also explored 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. Next, we established the effect of community-based sociotherapy on mental health in northern Rwanda. Finally, we theoretically explored the possible relevance of social capital for postconflict mental health recovery.

**Emergency psychosocial care in refugee camps**

At the time we implemented psychosocial intervention programs in refugee camps in Tanzania and the former Zaire (1994-1995, Chapter 3), most mental health programs in postconflict settings had a clinical orientation, focusing on trauma-related psychological problems. Although humanitarian aid organizations did provide help under the heading of ‘psychosocial,’ no publications existed on any such intervention models; most seemed to either focus on individual counselling or on the provision of community services. The model we envisaged in the refugee camps primarily aimed to help restore the communities’ own social support networks, by mobilizing the supporting potential of social circles such as formed by religious, professional, tribal or family relatedness. Individuals might be advised not to withdraw but to share time together, to seek or provide emotional support, distraction or practical help, or to fulfil certain activities or pursuits; to guide people to related community members who could provide support (relatives, neighbours, fellow-believers, etc.); to refer people to health or community services where necessary (e.g., in case of physical disease or obvious material needs). This appeared to be seriously hampered by the extreme distrust and animosity prevailing in the refugee populations. Other factors constraining the program’s success were the unfamiliarity with psychosocial issues among the emergency-oriented agencies involved, resistance to it among medical personnel, and the lack of guidelines for dealing with severe psychiatric
symptoms. The importance of the latter in complex emergencies was rightly stressed in a later publication by Jones and colleagues.\textsuperscript{20} The manuscript on this intervention program was published in 2000. Over the period between program implementation and its publication, there had been growing acknowledgement of the relative value of the use of western psychiatric concepts in psychological responses to suffering caused by war in crosscultural settings, especially of trauma-focused approaches.\textsuperscript{21-23} Thereby, our views underpinning a focus on social reintegration had been reinforced. A later survey among 64 acknowledged international experts on mental health and disaster management revealed the need felt to use both a clinical and a social approach, so as to include complementary components that address both individual clinical needs and broader needs of community revitalization.\textsuperscript{24} Over the first decade of the current century, various professionals in the field stressed the adequacy of a public health or ecological approach,\textsuperscript{25-27} and advocated for bridging the divide between trauma-focused and psychosocial frameworks.\textsuperscript{28} In a recent paper, Olff stressed the importance of the role of social support and bonding in processing psychological trauma, while linking this with human biological factors, i.e. the oxytocin system.\textsuperscript{29}

\textit{Community-based sociotherapy in an open setting}

The community-based sociotherapy program in Rwanda (Chapter 5), running from late 2005 onwards, uses a public health perspective in the sense that it is open to all experiencing psychosocial needs. While it primarily aims at social bonding and does not target specific mental health symptoms, our effect study suggests that it does have significant mental health effects. Apparently, it promotes mental health well-being or recovery for most participants, even though sociotherapy groups may comprise a whole spectrum of ‘cases’, from very problematic to doing rather well, and no mental health professionals are involved as group facilitators. The intervention model may serve as an example for community-based, community-level, psychosocial interventions for survivors of collective violence. It proved to be sustainable and to have the capacity to reach thousands of beneficiaries within years. It is in line with intervention models as suggested later in the literature,\textsuperscript{30} and with the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, a consenses document endorsed by all relevant players.\textsuperscript{31} In the “IASC pyramid,” the model would be classed at the level of interventions strengthening community and family supports, but it would easily allow the addition of focused, nonspecialized supports or specialized services for those for whom the program would not suffice. In Rwanda, specialized care could have complemented the program
for those still experiencing serious mental health problems after participation. Unfortunately, this has not been accomplished due to lack of resources.

**Effect measurement – instrument validation**

For measurement of the effect on mental health of the sociotherapy program in Rwanda, no locally developed, culturally grounded instrument was available.* Therefore, we validated an existing instrument (the SRQ-20) for use in Rwanda. We succeeded to also show its factorial invariance, which is a condition for its repeated use in a longitudinal study design. In concordance with the insights mentioned under the ‘Relevance of findings’ paragraph above, we used a general mental health screener instead of an instrument identifying symptoms of specific psychiatric disorders. This choice may not go unnoticed as it concerned a (longitudinal) effectiveness study, while obviously screening instruments are designed for use in cross-sectional designs.

**Effect measurement – outcomes**

Our effect study provided evidence of the effectiveness of a psychosocial intervention at community level in a low-income postconflict setting. Mean SRQ-20 scores decreased by 2.3 points in the experimental group and 0.8 in the control group ($P=.033$). Women in the experimental group scoring above cutoff at baseline improved with 4.8 points to below cutoff ($P<.001$), which suggests clinical relevance of our findings; men showed a similar trend.

In a recent review of 160 mental health and psychosocial support activities in humanitarian settings which were reported from 2007 to 2010, only 4 interventions classed in the “IASC pyramid” level of “strengthening community and family structures” concerned controlled studies. Three of these were programs for children and adolescents, and only one was targeting adults. The authors of the review in question, however, point at methodological weakness of the latter study. While to date there seems to be consensus on the way mental health and psychosocial support should be provided in postconflict settings, there is hardly any evidence yet for such programs targeting adults. This illustrates the relevance of the data yielded by our study.

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*A great drawback of using a culturally grounded instrument is that one cannot compare its findings to those from other settings. This disadvantage particularly applies to cross-sectional studies. For (longitudinal) effectiveness studies it seems less relevant. When using a context-specific instrument, an intervention’s effectiveness could be expressed through the proportion of subjects actually indicating improvement, and the same could be done in any other context by use of an instruments actually developed in that other context. Then, by taking proportions as outcomes, the effectiveness of the intervention at different locations could be compared equally well as with use of a universally used, standard instrument.*
Social capital
The final objective of this thesis was to explore the relevance of social capital for postconflict recovery, by establishing possible connections of social capital with mental health. We hypothesized that both social capital and mental health may intentionally be promoted through one sole intervention.

While the positive effect of the sociotherapy program in Rwanda on mental health has been evidenced (see above), qualitative information is in full support of its salutary effect on social capital. Additionally, quantitative postintervention data indicate a positive impact on one specific element of social capital, namely civic participation (Verduin et al., manuscript in preparation). It remains unclear, however, if, and how, the effects on both outcomes were related to one another. It has been suggested that various components of social capital are likely to each relate to mental health in their own way. Future challenges will be to establish if indeed specific elements of social capital are associated with mental health in war-affected populations and if these elements can be promoted by sociotherapy in different settings, and to unravel the possible links between the effects of such intervention on mental health and social capital, respectively.

Conclusions
The studies presented in this thesis were conducted under difficult circumstances, among populations who were not familiar with any form of research and mostly illiterate. Methods had to attune to the crosscultural nature of the studies. These studies, however, address issues of global relevance. Collective violence occurs on a daily basis in many parts of the world. The violence of war, genocide, repression, torture and other human rights abuses causes immense human suffering. This partly manifests itself through mental health symptoms. Our epidemiological studies added to the awareness of the extent of mental health needs prevailing in war-affected populations, and have shown to impact mental health policy and programming.

It has been acknowledged, however, that those needs are not expressed through psychiatric symptoms only. Problems of a predominantly social nature, whether pre-existing (e.g., extreme poverty) or violence-induced (e.g., the disruption of social networks), have an equally negative impact on postconflict recovery. Our studies have taken this a step further in various ways:

First, we have demonstrated that in nonwestern postconflict settings, it is feasible and culturally adequate to implement a large-scale psychosocial intervention which primarily aims at social reintegration, rather than focusing at recovery from psychiatric disorder. Additionally, by addressing the longitudinal validity of a screening instrument (the SRQ-20), we have shown that there is no need to focus on psychiatric diagnoses to measure an intervention’s effect on mental
health. Next, the sociotherapy program in Rwanda may serve as an example of a sustainable psychosocial intervention; it is the first such intervention reaching thousands of beneficiaries, with proven effectiveness on social capital and mental health.

These outcomes may have major implications for future mental health policy making and program planning in postconflict situations. They may also be relevant for western settings and specialized care settings, as is shown through the treatment program for traumatized refugees of the Equator Foundation in the Amsterdam region in the Netherlands, which equally focuses on mental health recovery and social rehabilitation and participation.
References


