Mental health in war-affected populations
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Chapter 10

Summary
Introduction
This thesis addressed the prevalence of mental health problems in populations in nonwestern war-affected regions, and methods to mitigate these problems through interventions focusing on social reintegration. At the time of our earliest studies, only limited knowledge existed about community-level prevalence rates of psychiatric symptoms in nonwestern postconflict areas. Also, methods in psychosocial aid provision were mostly undocumented. In general, however, the aid provided seemed to have an individual psychological orientation and use a trauma perspective.

In 1995, shortly after the genocidal violence in Rwanda, we performed an epidemiological study in refugee camps near the Thailand–Rwandan border. There, within the framework of an emergency program by Doctors Without Borders, we also started a psychosocial aid program with an innovative approach focusing on social reintegration. In 2003 we performed an epidemiological study in a strongly differing region, namely in an eastern province of Afghanistan. Over 2007 and 2008 we helped implement a psychosocial aid program in a northern district of Rwanda; it had similar objectives as the program in the refugee camps years before, but its approach was different.

Our study objectives were as follows: next to collecting epidemiological data, we wanted to establish the impact of these findings on the local mental health policy or on separate aid programs. We also wanted to establish the feasibility and adequacy of the psychosocial support programs mentioned above, taking into consideration their focus on social reintegration. Next, we wanted to establish the effect of the most recent intervention, the community-based sociotherapy program in Rwanda, on mental health. To that aim we needed to establish the validity for local use and for effect measurement of our instrument of choice, the Self Reporting Questionnaire (SRQ-20). Finally, we theoretically explored the relation between mental health and social capital, the latter being a construct which represents various elements of social cohesion within and between communities, and which may be a key resource supporting postconflict recovery.

This book comprises seven studies, set out in Chapters 2 to 8.

Epidemiological studies
Chapter 2 describes a prevalence study in 1995 among refugees in camps in Tanzania which arose as a result from the genocidal violence in 1994 in Rwanda. The camps harboured tens of thousands of refugees; the setting was chaotic and insecure, the social climate was politicized and the refugees were distrustful. Fifty percent of our respondents (n=854) had scores on the General Health
Questionnaire (GHQ-28) suggestive of serious mental health problems. This proportion would render any individual support offer completely inadequate. Our findings were indicative of the hugeness of the mental health needs in refugee camps, and called for a support offer reinforcing mutual support structures within the refugee community, rather than focusing on individual counselling. The publication of our study prompted the then secretary general of the WHO to write an accompanying editorial, in which she stressed the relevance of community-based psychosocial care as an integral part of any emergency response and of the health-care system in camps and national services.

Chapter 4 addresses a community level epidemiological study among the population of an eastern province of Afghanistan in 2003, after decennia of war and repression. As it had become clear by now that depression, posttraumatic stress and anxiety were the most prevalent mental health problems in postconflict regions, we focused this time on manifestations of these specific psychiatric disorders by use of the Hopkins Symptom Checklist and the Harvard Trauma Questionnaire. Symptoms of posttraumatic stress disorder (in 20,4%) and depression (in 38,5%) were indeed highly prevalent, but in particular anxiety was, more so in women (78,2%) than in men (21,9%). Over the past 10 years, 43.7% of the respondents (n=1011) had experienced 8 to 10 traumatic events, and 14.1% eleven or more. The main resources for emotional support were family and religion. These findings suggested that mental health symptoms should be addressed at the population and primary care level. Our study outcomes contributed to the awareness of mental health care at a national level; 4 months after the publication of our study the Ministry of Health in Kabul nominated mental health care as one of its top-10 priorities.

**Psychosocial interventions**

Chapter 3 describes the working model and implementation in 1995 of a psychosocial intervention program for Rwandan refugees living in camps, within the framework of a larger project of Doctors Without Borders. In this setting we also performed our first epidemiological study (see Chapter 2). The intervention model aimed at the identification and reinforcement of available resources for emotional and practical support, and at mobilizing people’s social networks. This constituted a shift away from the mainly trauma-focused approach which had become standard in situations alike. The intervention program could not be considered a complete success, mainly due to the prevailing anxiety and distrust among the refugees, the unfamiliarity with and resistance towards psychosocial issues among other (mostly emergency-oriented) agencies, and finally the untimely departure of Doctors Without Borders because of the
insecurity and misuse of relief goods in the camps. In retrospect the setting was too complicated to pilot the intended psychosocial approach, and the working model could have provided more grip to hang on to. Over the years after, however, worldwide consensus emerged about the need for psychosocial care programs in postconflict settings to use an approach with a focus as mentioned above.

**Chapter 5** addresses a psychosocial intervention program (community-based sociotherapy), started up by us and running from 2006 onwards in a northern district of Rwanda. It is aiming at social bonding and it does not target trauma symptoms in particular. The intervention comprises 15 weekly group sessions lasting half a day. Groups are facilitated by trained local community leaders. Participation is open to any adult person. Key elements of the working method are debates and the exchange of experiences and coping strategies among participants, exercises, and mutual practical support. Up to 40 groups of 10 to 15 participants run simultaneously, and since the start of the program over 10,000 people have participated. The program is appreciated widely, has expanded to other parts of Rwanda and neighbouring countries, and has independently been run by local organizations for years now. It thus appears to be a feasible, locally adequate and sustainable community-based intervention method, which, by use of a public health approach, meets the most relevant quality demands on humanitarian aid in such settings.

**Instrument validation & effect measurement**

**Chapter 6** addresses the validation process of the Self Reporting Questionnaire (SRQ-20) for local use in Rwanda. The SRQ-20 is an instrument developed by the WHO to screen for possible mental health problems. We aimed to use the SRQ-20 to measure the effect of sociotherapy (see Chapter 5) on mental health. Therefore, its translated version had to meet the criteria for culture-specific use. Besides, the instrument should have longitudinal validity in order to be used for effect measurement; the SRQ-20 had never been tested with regards to this possible quality before. We were able to show both the cultural and the longitudinal validity of the Rwandan translation of the SRQ-20. Establishment of the instrument’s longitudinal validity has relevance beyond our particular effect study: effect studies of mental health interventions are mostly done by measuring symptoms of specific psychiatric disorders, while there seems to be worldwide consensus about the relative meaning of psychiatric diagnoses in postconflict contexts. Our study showed that mental health intervention outcomes can also be established by use of a measure for general psychological well-being: the SRQ-20, an instrument used in numerous settings.
Chapter 7 describes our study to establish the effect on mental health of the community-based sociotherapy program in northern Rwanda, by use of the now validated SRQ-20. We used a controlled study design, with three measurement moments: right before and directly after the series of group sessions, and at 8 months follow-up. The control group comprised inhabitants of the region who did not participate in sociotherapy. Despite the intervention's focus on social bonding, it was shown to have a significant positive effect on mental health: the experimental group's mean SRQ-20 scores decreased by 2.3 points \( (P=.033) \). This effect continued at follow-up after 8 months. Women in the experimental group scoring above the locally established cutoff at baseline improved with 4.8 points to below cutoff \( (P<.001) \), a clinically relevant outcome. This is the first controlled study in history on the effect of a large-scale community level psychosocial intervention in a postconflict setting.

Social capital
Chapter 8 is a theoretical study on the construct of social capital, taking off with a summary of relevant literature on the relation of social capital with health and well-being, and with mental health in particular. Social capital is a measure for cohesion within and between communities; it encompasses concepts like network, mutual trust, reciprocity and cooperation. The larger a community's social capital, the more potential it seems to have for both economic growth and certain aspects of health and well-being. Therefore, social capital is potentially a key resource supporting postconflict recovery. Social capital's relation with mental health seems to be more complex. Qualitative research in Rwanda, however, unambiguously showed a positive effect of sociotherapy on social capital, while our quantitative study (see Chapter 7) established its effect on mental health. Support aimed at the increase of social capital thus seems to be potentially effective with regards to mental health. This may serve as another argument in favour of particularly directing psychosocial support programs in such contexts at social bonding and cooperation.

Conclusions
The epidemiological studies within this thesis yielded high prevalence rates of mental health problems and possible psychiatric disorders among nonwestern war-affected populations. These findings not only called for psychosocial care as an integral part of the emergency response and health care in postconflict regions, but also showed that such aid should be provided at the community or primary care level and preferably be community-based. Professionals around
the world have meanwhile become aware that in postconflict regions, symptoms as established through epidemiological studies may not indicate the presence of psychiatric disorders. Our studies on intervention programs focused on psychosocial support programs aiming at social reintegration and bonding, thereby leaving the individual psychological (trauma-)perspective. The effect on mental health of such interventions may be established through measuring general mental health rather than symptoms of psychiatric disorders. The community-based sociotherapy program in Rwanda reached a large number of people and positively affected social bonding. Our controlled study showed an additional positive effect on mental health. This may be indicative for both the existence of a relation between social capital and mental health and the possibility to impact these two factors through one single intervention. The latter seems to be a relevant finding with regards to efforts to support recovery after mass violence.