# Conflict Situations and Mental Health Care in Developing Countries

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## Abstract

Mental health professionals from developing countries have studied the impact of conflict situations in terms of their impact on the lives of the general population, levels of distress and prevalence of mental disorders. There are higher rates of all of these dimensions of mental health in the population as a consequence of living in conflict situations, with women and children being the most vulnerable. There have been many innovative approaches to address mental health needs ranging from individual interventions, through school based interventions to community level interventions. The difficulties of addressing the multiple and complex mental health needs of populations calls for greater attention to the prevention of conflict situations. Mental health professionals and international organizations have an important role regarding the prevention of conflict situations.

> ***"If you blow into the coals, you will either make fire or will be covered by ash"***
> ***— Yemeni Proverb***

## Introduction

Wars and conflict situations have played an important role in the development of mental health care in the world. It was the psychological impact of the two world wars of the last century, described variously as "shell shock", "not yet diagnosed", "nervous" and "battle fatigue", that brought into focus the effects of war on the mental health of individuals

and supported the use of psychological interventions. Further, it was the recognition of a significant proportion of the population not suitable for army recruitment, due to mental health issues, during the Second World War that spurred the setting up of the National Institute of Mental Health in the USA. The differences in the presentation of the psychological symptoms among the officers and the soldiers opened up new ways of understanding psychiatric reactions to stress (Srinivasa Murthy, 2007).

At a macro level, the year 2014 marks the one-hundredth anniversary of the First World War and the 70th anniversary of the Normandy invasion. It also marks the 20th anniversary of the Rwandan massacre. There has also been more than a decade of involvement of foreign forces in Afghanistan and Iraq. The World Health Organisation (WHO) has published a comprehensive progress report titled "**Building Back Better-Sustainable mental health care after emergencies"** describing the progress in Afghanistan, Burundi, Indonesia, Iraq, Jordan, Kosovo, Somalia, Sri Lanka, Timor-Leste and West Bank and the Gaza Strip. For each of the countries, there is a description of the context, turning the emergency into an opportunity to rebuild better, progress made and the lessons learnt (WHO, 2013).There is a recent update of the literature on "Disaster Psychiatry" by the American Psychiatric Association (Stoddard et al., 2011).

At a micro level, as I complete the manuscript of this chapter, there is a resurgence of violence in Iraq and South Sudan, and continuing violence in Afghanistan, Libya, Syria and Somalia.

The first Global Summit to "End Sexual Violence in Conflict" held in London (10–14 June 2014) noted that "War zone sexual violence and other forms of gender-based violence inflict extreme suffering and represent serious violations of human rights. These crimes leave physical, psychological, social and economic scars on individuals, families, and communities".

The topic on which I am writing has a special meaning to me. At a personal level, 2014 also marks the 30th anniversary of the Bhopal disaster, a disaster that I have been associated with and through which I have learnt a lot about human suffering and resilience following disasters. During the last three decades, I have worked in many disaster situations in India and other developing countries, organizing mental health care, and in countries in conflict situations such as Afghanistan, Iraq, Iran, Sudan and Somalia. In the last four years, I have been part of an international group

looking at "Peacemaking and Psychosocial interventions" located in Belfast, Ireland. The project brought together experiences from various countries (Brandon and Gallagher, 2015).

It is all these experiences that I reflect upon in this chapter.

Eight years back I had reviewed the literature relating to mass violence and mental health (Srinivasa Murthy, 2007). In this chapter, I will review the developments in this field in terms of prevalence of mental disorders in some of the countries in conflict situations and the new interventions to address mental health needs in the last eight years. Further I will reflect on mental health care in developing countries in conflict situations based on my work in Iraq, Sudan, South Sudan, Afghanistan and Somalia. The attempt is not to be comprehensive but reflective of the issues in this field.

## Recent Prevalence studies

Data on the prevalence of mental disorders in populations exposed to conflict situations are available from a number of sources. There are studies of general populations and studies of specific population groups such as women, children, ex-combatants and army personnel. There are also clinical studies of ill population groups. Rates of a wide range of mental health problems increase as the result of emergencies and conflict situations. WHO projections of mental disorders in adult populations affected by emergencies (i) for severe disorders is 3–4% as against 2-3% before the emergency; (ii) for mild and moderate mental disorders is 15–20% as against 10% before the emergency and (iii) reveal normal distress to be reported by the large percentage of the population (WHO, 2013).

### United States of America (USA) (IOM, 2014)

Studies in the USA are the most comprehensive and provide valuable data about the impact of exposure of a healthy population to conflict situations. The National Comorbidity Survey Replication, conducted in 2001–2003, estimated that the 12-month prevalence of PTSD in the US adult population was 3.6% and that the lifetime prevalence was 6.8%. Women were more likely than men to have PTSD (9.7% vs 3.6% for lifetime) (Harvard Medical School, 2007, 2007b). Another national survey, the 2004–2005 National Epidemiologic Survey on Alcohol and Related Conditions, found a lifetime prevalence of PTSD of 7.3% (Roberts et al, 2011). The incidence of PTSD in recruit trainees throughout the service

branches in 2000–2012 was 3.3 per 1,000 person-years or 0.1% of the total recruit trainee population, and the incidence was higher in female than in male recruit trainees (11.5 vs 1.7 per 1,000 person-years) (Monahan et al, 2013). From 2004 to 2012, the PTSD rate increased from 1.2% to 7.0% in active-duty service members, from 1.8% to 6.7% in reservists, and from 4.0% to

20.7% in retirees. Most of the cases of PTSD were seen in service members who had been deployed. The data on ranks shows that 2012 rates were lower in officers (4–5%) and warrant officers (7%) than in junior and senior enlisted personnel (11% and 10%, respectively) (Kennell et al, 2013). A study of note is into the relationship between the severity of an injury and PTSD symptom severity. In a study of 1,402 OEF and OIF veterans, it was found that the prevalence of combat-related PTSD and symptom severity increased with the severity of the injury. The prevalence of PTSD was 8% in those without any injuries, 13% in those with a penetrating injury, 29% with blunt trauma, and 33% with combination injuries (Mc Lay et al, 2012). PTSD was one of the top five reasons for referrals to the behavioural health restoration centre in Afghanistan in 2009 and 2010. The Army Mental Health Advisory Team (MHAT-7) found that the fraction of referrals due to PTSD increased from 4% in 2009 to 7% in 2010 (WHAT-7, 2011).The review concludes: “Data from DoD and VA show marked increases in PTSD among military service and veteran populations. Although these numbers are likely to underestimate the incidence and prevalence of PTSD, they demonstrate that action is needed to respond to this growing problem” (IOM, 2014).

## Rwanda

A number of studies have addressed issues of prevalence of PTSD, sexual violence, grief and trans-generational distress in Rwanda.

Schaal et al. (2009) studied the prolonged grief disorder (PGD) and depression in widows due to the Rwandan genocide. Forty widows who had lost their husbands during the Rwandan genocide in 1994 were assessed as suffering from Major Depression using the Mini-International Neuropsychiatric Interview (M.I.N.I.) and prolonged grief reactions using the PG-13. 12.5% of the sample fulfilled the criteria for a diagnosis of PGD; 40% met criteria for a major depressive episode. The two syndromes were strongly associated.

Schaal et al. (2012) studied, 15 years after the killings in Rwanda, the mental health among the imprisoned perpetrators of the genocide against the Tutsi versus a community sample of survivors to compare rates of mental health disorders in Rwandan genocide perpetrators with those of genocide survivors and to investigate potential predictors of symptoms of post-traumatic stress disorder (PTSD) and depression for both groups. Structured clinical interviews were carried out with 269 imprisoned perpetrators (66% men) and 114 survivors (64% women). Significantly more survivors than perpetrators met symptom criteria for PTSD (46% vs 14%) and suffered from anxiety symptoms (59% vs 36%). A substantial proportion of both groups suffered from clinically significant depression (46% vs 41%). PTSD severity in perpetrators was associated with trauma exposure, high levels of agreement to reconciliation and no participation in killing; the severity of depression was associated with trauma exposure and no participation in killing. In the survivor sample, the severity of PTSD and depression were both correlated with female gender, trauma exposure and low levels of agreement to reconciliation. Results suggest that both groups exhibit considerable psychiatric morbidity.

Munyandamutsa et al. (2012) studied the mental and physical health in Rwanda 14 years after the 1994 genocide in a large random sample of the Rwandan population. 1000 adult residents from the five provinces of Rwanda were interviewed. Prevalence of PTSD was estimated to be 26.1%. In multivariable analysis, factors associated with PTSD were being aged between

25 and 34 years, living in extreme poverty, having endured the murder of a close relative in 1994, being widowed or remarried, having lost both parents and living in the South Province. Participants who fulfilled the diagnostic criteria for PTSD were significantly more often affected with major depression (68.4 vs 6.6%) and substance dependence (7.6 vs 3.5%) than respondents without PTSD. Somatic symptoms such as hiccups, fainting and loss of speech or hearing delineated a specific pattern of post-traumatic stress syndrome. Authors conclude “PTSD remains a significant public health problem in Rwanda 14 years after the genocide. Facilitating access to appropriate care for all those who need it should be a national priority”.

Roth et al. (2014) studied the trans-generational consequences of PTSD. A community sample of 125 Rwandan mothers who experienced the genocide of 1994 and their 12-year-old children were interviewed. Maternal PTSD was not associated with the child’s psychopathology. Instead, a child’s

exposure to maternal family violence posed a significant risk factor for a negative mental health outcome. Furthermore, it was not maternal PTSD-symptoms but the mother's exposure to family violence during her own childhood that was associated with the magnitude of adversities that a child experiences at home.

Rieder and Elbert (2013) studied the relationship between organized violence, family violence and mental health in a community-based survey in Muhanga, Southern Rwanda. One hundred and eighty-eight parent-child pairs from four sectors of the district Muhanga, Southern Province of Rwanda, were randomly selected for participation in the study. Prevalence rates of child abuse and neglect among descendants were below 10%. Ordinal regression analyses revealed that the level of child maltreatment in descendants was predicted by female sex, poverty, loss of the mother, exposure to war and genocide as well as parents' level of PTSD and reported child maltreatment. Poor physical health, exposure to war and genocide, parental PTSD symptoms, and reported childhood trauma were significantly associated with depressive and anxiety symptoms, while only exposure to war and genocide and poor physical health predicted the level of PTSD. Authors conclude that cumulative stress such as exposure to organized violence and family violence in Rwandan descendants poses a risk factor for the development of depressive and anxiety symptoms.

Richters et al. (2013) examined sexual transgression and social disconnection and the role of healing through community-based sociotherapy. In 2005, a community-based sociotherapy programme was introduced into the context of mental and social distress, to help people regain feelings of dignity and safety and to reduce distress. The authors explored how sociotherapy, as a specific form of peer group counselling, can facilitate the healing of suffering related to issues of sexuality, violence within the family and the breakdown of social connections on a community level.

## South Sudan

South Sudan, the youngest nation in the world, signed the Comprehensive Peace Agreement in January 2005 marking the end of the civil conflict in Sudan lasting over 20 years. The conflict was characterized by widespread violence and large-scale forced migration.

Roberts et al. (2009) carried out a general population epidemiological study in the capital city of Juba. A cross-sectional, random cluster survey

with a sample of 1242 adults (aged over 18 years) was conducted in November 2007 in the town of Juba, the capital of Southern Sudan. Levels of exposure to traumatic events and PTSD were measured using the Harvard Trauma

Questionnaire and levels of depression were measured using the Hopkins Symptom Checklist-25.

Over one third (36%) of respondents met the symptom criteria for PTSD and half (50%) of respondents met the symptom criteria for depression. The multivariate logistic regression analysis showed strong associations of gender, marital status, forced displacement and trauma exposure with outcomes of PTSD and depression. Men, IDPs, and refugees and persons displaced more than once were all significantly more likely to have experienced eight or more traumatic events.

Singh and Singh (2014) have reported on the current state of mental health services in South Sudan. There are only one psychiatrist, two clinical officers and no community psychiatric nurses. There are only six nurses working in the outpatient and the inpatient clinic at the Juba Teaching Hospital. With the recent upsurge in violence, the situation is going to get worse for the population, particularly for people with a mental disorder.

## Somalia (WHO, 2010)

There is no clear national picture on the prevalence of mental disorders. It is generally accepted that the current prevalence of mental health disorders is quite high, considering that the country has not only suffered from the cruelty of the civil war and ineffective foreign interventions but also from a tremendous state of insecurity and violence at all levels of the community. In addition, there is a continuous impoverishment of the already poor resources, harsh droughts and a more than eighteen year lack of authority and government institutions. The importance of mental health care to the population is also confirmed by a recent declaration by local authorities, who prioritized mental health as one of the key sectors that needs to be addressed within the health framework.

## Afghanistan

Prevalence studies in the general populations have been carried out regularly during the last three decades (Srinivasa Murthy, 2007).There have been a number of new studies about the prevalence of mental

disorders as well as the various forms of distress and difficulties of living experienced by the population.

Former Deputy Health Minister Faizullah Kakar completed a study (published in Dari) indicating that rising numbers of women and girls aged 15-40 are attempting suicide in Afghanistan. Of the over 100 cases of self-immolation registered at the burns ward of Herat City Hospital over the past 15 months, 76 had died, officials said. "A lot of the women who commit self-immolation or suicide suffer from mental disorder", said Mohammad Arif Jalali, head of the hospital's burns ward.

Eggerman and Panter-Brick (2010) conducted, in 2006, face-to-face interviews with 1011 children (age 11–16) and 1011 adult caregivers, randomly selected in a school-based survey in three northern and central areas. Participants narrated their experiences as part of a systematic health survey, including an open-ended questionnaire on major life stressors and solutions to mitigate them. For adults, the primary concern is repairing their "broken economy", the root of all miseries in social, educational, governance and health domains. Students reported frustrations in learning environments as well as poverty, as education is perceived as the gateway to upward social and economic mobility. Hope came from a sense of moral and social order embodied in the expression of key cultural values: faith, family unity, service, effort, morals and honour. These values form the bedrock of resilience, drive social aspirations and underpin self-respect and dignity. However, economic impediments, social expectations and cultural dictates also combine to create entrapment, as the ability to realise personal and social aspirations is frustrated by structural inequalities injurious to health and wellbeing. This study demonstrates that culture functions both as an anchor for resilience and an anvil of pain and highlights the relevance of ethnographic work.

Panter-Brick et al. (2008; 2009; 2011) carried out a series of studies in children, using stratified random-sampling in schools. Mental health and life events for 11- to 16-year-old students and their caregivers were assessed. With the exception of post-traumatic stress, one-year trajectories for all mental health outcomes showed significant improvement. Family violence had a striking impact on the Strengths and Difficulties Questionnaire data, raising caregiver-rated scores by 3.14 points; past-year traumatic beatings independently raised self-rated scores by 1.85 points. A major family conflict raised depression scores by 2.75 points, whereas improved family life had protective effects. Post-traumatic stress symptom scores were solely contingent on lifetime trauma, with more than three

events raising scores by 5.38 points. The authors conclude that family violence predicted changes in mental health problems other than post-traumatic stress symptoms in a cohort that showed resilience to substantial socioeconomic and war-related stressors.

### Sri Lanka

Tol et al. (2011; 2012) have reviewed the mental health needs of the Sri Lankan population. They conclude: "The civil war in Sri Lanka, which ended in 2009 when government security forces claimed victory over the Liberation Tigers of Tamil Eelam, has had an extensive impact on the mental health of the population". A number of epidemiological studies have documented the high prevalence of mental disorders among children in Sri Lanka. Two studies in the northeast of the country found prevalence rates of 25% and 30% for post-traumatic stress disorder (PTSD) and 20% for major depression. In addition, researchers have observed increased psychological distress among the general population and detrimental impacts of the long-term conflict on social structures, including family and community functioning in the north and east of Sri Lanka.

Silove et al. (2014) report a 6-year longitudinal study from Timor-Leste, the effects of recurrent violence on post-traumatic stress disorder and severe distress in conflict-affected Timor-Leste. The team assessed 1022 adults exposed to mass conflict in 2004, and again in 2010–11, following a period of internal conflict. The prevalence of PTSD increased from 2.3% in 2004 to 16.7% in 2010. Having PTSD was associated with being women, experience of human rights trauma, exposure to murder, ongoing family or community conflict, or preoccupation with injustice for two or three historical periods. The authors draw attention to the need for "prevention of recurrent violence, alleviating poverty, and addressing injustices in countries emerging from conflict".

## Children at War

One of the most vulnerable victim groups of conflict situations is that of children. Singer (2006) describes the impact as follows: "For those children who are forcibly taken, it is often 'a journey of hell' . Abduction is by definition an act of violence that rips terrified children from the security of their families and relatives. Killings, rapes, and severe beatings often accompany it. Once caught, children have no choice; usually they must comply with their captors or die".

The growing evidence of the long-term/lifelong impact of childhood trauma and abuse and the biological changes that accompany these experiences shows this group to be most vulnerable to conflict situations (Srinivasa Murthy, 2014).

## Narratives from conflict situations

The epidemiological data have a value of their own for scientific study of conflict situations. However, equally relevant are the narrative accounts of the ordinary people living in conflict situations. In recent years, from countries in conflict there have been a large number of narratives of the general population written, both as fictional stories and non-fiction. These are important as they present the impact of the conflict situations on the ordinary people and their day-to-day lives. This has been covered elsewhere (Srinivasa Murthy, 2015).

## Mental health interventions

The WHO report of 10 countries (2013) presents a wide range of interventions in the countries covered by the report. A few of the significant interventions are described below.

Ayoughi et al. (2012) compares the efficacy of psychosocial counselling with routine pharmacological treatment in a randomized trial in Mazar-e-Sharif (Afghanistan).

Sixty-one help-seeking Afghan women, who were diagnosed with mental health symptoms by local physicians, either received routine medical treatment or psychosocial counselling (5–8 sessions) following a specifically developed manualized treatment protocol. At 3-month follow-up, psychosocial counselling patients showed high improvements with respect to the severity of symptoms of depression and anxiety. In addition, they reported a reduction in psychosocial stressors and showed an enhancement of coping strategies. At the same time, the severity of symptoms, the quantity of psychosocial stressors and coping mechanisms did not improve in patients receiving routine medical treatment. Authors conclude that psychosocial counselling can be an effective treatment for mental illnesses even for those living in ongoing unsafe environments.

Scholte et al. (2009), in Rwanda, developed and implemented a very innovative way of addressing the mental health needs at the community

level. They used a prospective quasi-experimental study design with measurement points pre- and post-intervention and at 8 months follow-up. One hundred adults from both sexes in the experimental condition entered the study; follow-up measurements were taken from 81. A control group of 100 respondents with similar age, sex and symptom score distribution from a random community sample in the same region was used; of these, 73 completed the study. Mental health was assessed by use of the Self Reporting Questionnaire (SRQ-20), a twenty item instrument to detect common mental disorders in primary health care settings. Mean SRQ-20 scores decreased by 2.3 points in the experimental group and 0.8 in the control group. Women in the experimental group scoring above cut-off at baseline improved with 4.8 points to below cut-off. Men scoring above cut-off at baseline showed a similar trend which was statistically non-significant. No adverse events were observed.

Connolly and Sakai (2011) describe brief trauma intervention with Rwandan genocide-survivors using thought field therapy. This randomized waitlist control study examined the efficacy of Thought Field Therapy (TFT) in reducing post-traumatic stress disorder symptoms in survivors of the 1994 genocide in Rwanda. Participants included 145 adult genocide survivors randomly assigned to an immediate TFT treatment group or a waitlist control group. Reduced trauma symptoms for the group receiving TFT were found on all scales. Reductions in trauma symptoms were sustained at a 2-year follow-up assessment.

From Sri Lanka, Wietse et al. (2012) describe a school-based intervention for children affected by war in Sri Lanka. A cluster randomized trial was employed. Subsequent to screening 1,370 children in randomly selected schools, 399 children were assigned to either an intervention (n=199) or waitlist control condition (n=200). The intervention consisted of 15 manualized sessions over 5 weeks of cognitive behavioural techniques and creative expressive elements. Assessments took place before, 1 week after, and 3 months after the intervention. Primary outcomes included post-traumatic stress disorder (PTSD), depressive, and anxiety symptoms. No main effects on primary outcomes were identified. A main effect in favour of intervention for conduct problems was observed. This effect was stronger for younger children. Furthermore, we found intervention benefits for specific subgroups. Stronger effects were found for boys with regard to PTSD and anxiety symptoms, and for younger children on pro-social behaviour. Moreover, we found stronger intervention effects on PTSD, anxiety, and function impairment for children experiencing lower levels of current war-related stressors. Girls in the intervention condition showed

smaller reductions in PTSD symptoms than waitlisted girls. We conclude that preventive school-based psychosocial interventions in volatile areas characterized by ongoing war-related stressors may effectively improve indicators of psychological wellbeing and post-traumatic stress-related symptoms in some children. However, they may undermine natural recovery for others. Further research is necessary to examine how gender, age and current war-related experiences contribute to differential intervention effects.

**Box 1:** ***As I was completing the chapter, a series of articles in the Los Angeles Times, regarding post-traumatic stress disorder among veterans, brought home the complexity of the mental health impact on soldiers involved in conflict situations. The 8 August 2014 article was titled "PTSD continues to afflict Vietnam veterans 40 years after the war", and reported that forty years after the end of the Vietnam War, 11% of veterans continue to suffer from post-traumatic stress disorder (Zaremto, 2014). The research updates a landmark study conducted in the 1980s, when researchers found that 15% of Vietnam veterans had the disorder. Despite the passage of many years and the increasing availability of effective treatments for PTSD, the picture remains much the same. It was further noted that 31% of Vietnam veterans had suffered from PTSD at some point in their lives, but that by the late 1980s about half no longer did. Among veterans who were deployed to Vietnam, those who had the disorder in the 1980s were twice as likely as those without it to be dead today. Roughly 1 in 4 had died. Their death rate from cancer was particularly elevated, possibly because those with PTSD are more likely to smoke. How care should occur is debated in "Better to treat too many veterans for PTSD than too few". However, an earlier article focused on the disability claims as follows: "As disability awards grow, so do concerns with veracity of PTSD claims". One psychologist and ex-Marine estimates that half of the veterans he evaluates exaggerate or fabricate symptoms. As disability awards for PTSD have grown nearly fivefold over the last 13 years the motivation behind such advice is not always clear. It may be aimed at helping veterans get what they deserve from a system that many see as rigged against them. Exaggeration can also be a sign of distress itself. Dilemmas about PTSD are seen at many levels: For example, several VA mental health providers said the incentives of the disability system have undermined their relationship with patients and inhibited them from fully engaging in treatment. One lady responded to the debate as follows: "This article makes me livid. My husband has PTSD and my children and I are suffering from his behavior. Because of this type of article, it makes my husband ashamed to get help. He does not want to seek help because he doesn't want people to think he is using the system, which he is not!"***

## Discussion

A series of measures have focused on the mental health needs of populations in emergency situations (IASC, 2007; WHO, 2013). There are a number of themes that emerge from the review of the developments of the last few years.

WHO (2013) summarizes overlapping practices among 10 countries in emergency situations. The following commonalities were identified (table 1):

**Table 1: Lessons learnt from mental health care in countries in emergency situations (WHO, 2013).**

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| 1. Mental health reform was supported through planning for long-term sustainability from the outset |
| 2. The broad mental health needs of the emergency-affected population were addressed |
| 3. The government's central role was respected |
| 4. National professionals played a key role |
| 5. Coordination across agencies was crucial |
| 6. Mental health reform involved review and revision of national policies and plans |
| 7. The mental health system was considered and strengthened as a whole |
| 8. Health workers were reorganized and trained |
| 9. Demonstration projects offered proof of concept and attracted further support and funds for mental health reform |
| 10. Advocacy helped maintain momentum for change |

In an earlier review of the development of disaster mental health care in developing countries (Srinivasa Murthy, 2007) I identified seven factors as major obstacles for the initiation of well-functioning mental health and psychosocial intervention programmes in conflict situations (table 2).

**Table 2: Barriers to mental health care in conflict situations (Srinivasa Murthy, 2007)**

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| • Shortage of national professional leadership |
| • Absence of infrastructure to support mental health and psychosocial programmes |
| • Stigma about mental disorders |
| • Multiple models of interventions |
| • Lack of Funding |
| • Competing interests of NGOs and UN organizations |
| • Insufficient political will and political instability |

There are three aspects that call for discussion from experiences of conflicts and their relationship with mental health, namely, (i) the increased prevalence of mental distress and disorders in populations living in conflict situations; (ii) the methods adapted to meet mental health needs; and (iii) prevention of conflicts and wars.

## Prevalence and pattern of mental disorders

The current selective review, similar to an earlier exhaustive review (Srinivasa Murthy, 2007) shows higher rates of mental disorders in the general population along with a wide range of "distress" and "disruption of lives". What is striking about the recent studies, as noted by Hicks (2014) is "the integration of high quality epidemiological sampling and validated mental health measures with information about the relevant social conditions, [and] a good qualitative grounding.… The identification of trauma events as human rights violations is being increasingly noted". A large number of narratives of individual lives from all countries reviewed add the "human dimension" of conflict situations. This combination of the scientific with the qualitative is an important advance in this field.

## Meeting mental health needs

A wide range of interventions addressing needs at levels ranging from individuals, through families to communities have been described. A more recent trend is to link psychosocial interventions with development and peace building. The efforts included in the review demonstrate both the feasibility of addressing mental health needs in the most challenging situations (e.g. Afghanistan, Ayoughi et al., 2012) and the scope for innovation to reach community level interventions (Scholte et al., 2009). Equally important is the evaluation of interventions (Tol et al., 2012). One other aspect, that of the mental health interventions for mental health professionals, comes from work in Sri Lanka and Palestine. A psychologist in Gaza recalls, through clenched teeth, that his young daughters have now experienced three wars. "Can you imagine what that means to the new generation?" he said. "Scared parents cannot assure or secure scared children." It is difficult – even absurd, the clinicians say at their darkest moments – to try to mend psyches in the Gaza Strip, where even in calmer times the conditions are hardly conducive to psychological health, and safety is never more than provisional under the many cease-fires that have come and gone (Barnard, 2014).

## Prevention of conflicts and wars

There is growing recognition among public health professionals and mental health professionals that it is often pointless to measure morbidity, intervening to address the devastations of conflict situations (Horgan, 2011; Wiist et al., 2014). There are, however, some serious professional attempts to address the issue of prevention of conflicts.

The American Public Health Association, in its position paper (APHA, 2009) addressed the role of public health practitioners, academics and advocates in response to war and armed conflict. The position paper provides the scientific basis and justification for an acknowledgment that war has been among the most important public health problems of the last 100 years, and there is little evidence its importance is waning. We who have committed our careers to promoting public health need to change our framework to encompass war as one of the most significant threats to the health of people in every demographic group and in every country. Practitioners, educators, and other workers in public health can play powerful roles in preventing war itself, as well as mitigating the public health consequences of war. The public health consequences of war are massive and leave few if any areas of public health practice untouched.

Thus, war is one of the greatest obstacles to realizing APHA's vision of "a healthy global society".

The paper recognizes that public health practitioners, academics and advocates have an essential role to play in preventing war. It calls on public health professionals and international and domestic organizations to (i) recognize the prevention of war as a local, national and global public health priority; (ii) educate public health professionals, policymakers and the public about the anticipated consequences of war and advocate for alternative resolutions to conflict; (iii) encourage and support research and advocacy relating to the structural causes of conflict, trends in risk to civilians from state and non-state actors, assessment of impacts anticipated from wars that have not yet started, comprehensive monitoring and surveillance of public health impacts in conflict zones, factors in successful settlement, the rapid rebuilding of health systems infrastructure as part of post-conflict reconstruction, and identifying ways to prevent war and to mitigate its health consequences; (iv) foster dialogue on the issue of war and build partnerships with international public health stakeholders; and (v) improve the competency of the global public health workforce to prevent and mitigate the impacts of war. Reviewing the limited progress in the last five years, Wiist et al. (2014) note "public health has been more focused on the effects of war than working towards the prevention of the fundamental causes of war.… Public health practitioners and academics have an obligation to take a lead role in the prevention of war by addressing the fundamental causes in society that lead to war".

The above five roles are applicable to mental health professionals.

## Conclusions

As a psychiatrist working with populations affected by disasters and people living in conflict situations, the predominant feeling I carry with me is one of extreme helplessness. We confront disintegration of individuals, families and communities with limited scope for interventions. The interventions are most often inadequate and the populations continue to suffer in silence for decades at many levels. My feelings are in line with that of Gall (2014), a reporter who has worked in Afghanistan: "Over twelve years, I lost friends and acquaintances in suicide bombings and shootings, and saw others close to me savagely maimed. I do not pretend to be objective in this war. I am on the side of

the victims. **The human suffering has been far too great, and we have a duty to ponder for the reasons for such a calamity"** (emphasis added).

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