ORIGINAL RESEARCH

The Challenges Facing Mental Health Programs for Post-Conflict and Refugee Communities

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Abbreviations:
PTSD = post-traumatic stress disorder

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Abstract

The majority of refugees and communities exposed to warfare and oppression live in low-income countries with few resources or special skills. Yet, epidemiological studies have identified high levels of traumatic stress reactions in such populations. These stress reactions can be intensified by harsh policies aimed at deterring survivors from seeking refuge in technologically advanced societies. The scale of the problem of mass violence and displacement creates formidable challenges for mental health professionals in their efforts to develop practical frameworks for responding to the extensive needs of displaced persons. In this article, a model is proposed for low-income, post-conflict countries, based on a two-tiered formulation. At the eco-social level, mental health professionals can play a supportive, but not a lead, role in facilitating recovery of core adaptive systems that hasten natural recovery from stress for the majority of the population. Where small-scale, community mental health services are established, the emphasis should be on assisting persons and their families who are at greatest survival and adaptive risk. Training and promotion of local workers to assume leadership in such programs are essential. In technologically advanced societies in which refugees are in a minority, torture and trauma services can focus more specifically on traumatic stress reactions, acculturation, and resettlement. In a historical epoch in which displaced persons are facing particularly harsh treatment, there is a pressing need for consensus amongst mental health professionals in advocating for their needs.

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Introduction

Most contemporary wars and related forms of mass conflict occur in low-income countries whose infrastructure, skills base, and services are poorly developed.[1] In these settings, mental health services generally receive low priority, even though mass violence impacts on mental health in several ways. Direct impacts include the precipitation of traumatic stress and grief-related psychological disorders. In addition, erosion of social supports places those with pre-existing mental disturbances at increased risk.[2] Also, in settings of prolonged conflict and underdevelopment, services are poorly developed or undermined, and mental patients often are neglected or undertreated.[2]

In spite of these wide-ranging mental health issues, research amongst refugees has been limited almost exclusively to the area of traumatic stress, with comparatively little attention being given to the needs of the severely mentally ill in post-conflict environments. At the same time, psychosocial recovery programs focusing primarily on traumatic stress, especially those initiated in the former Yugoslavia after the wars in that region, have attracted substantial criticism.[3] These issues suggest the need for a broader formulation of the role of mental health initiatives in low-income, post-conflict countries.[4] This pre-

sent article will draw on the existing literature as well as on my own experience in post-conflict East Timor and other settings,[2,5] in order to propose a model. The framework attempts to reconcile mental health initiatives with the overall mission of humanitarian aid efforts for conflict-affected communities. It is argued that mental health professionals have a supportive role in the broad-based social recovery initiatives that allow affected communities to regain their psychological equilibrium. Where direct community mental health services are offered, it will be argued that the focus should be on the minority of persons at immediate social and survival risk as a consequence of mental disturbances of any kind, thereby attending to one of the most vulnerable groups of concern to the relief mission.

Psychological Trauma and Post-Conflict Settings

Psychological trauma requires special reconsideration in formulating a broader model of mental health intervention in post-conflict settings. The introduction of post-traumatic stress disorder (PTSD) as a separate category in DSM-III (1980) led to a burgeoning of research and clinical work in the field of traumatology.[6] The focus of interest has ranged over a wide domain, covering areas as diverse as technological and natural disasters, road trauma, assault and rape, and the impact of war, torture, and mass displacement.[7] Inevitably, questions arise whether a core foundation of knowledge about trauma has emerged that is applicable across the diversity of experiences, contexts, and cultures in which survivors are located. A particular concern is whether the individual-focused psychological therapies applied in technologically advanced societies are applicable to the diverse cultures and social settings found in low-income, post-conflict countries.[8]

The Scale of the Problem

Western diagnostic systems, such as DSM-IV, are individual-focused, aiming to identify disturbances experienced by the person rather than by the group or society as a whole. The challenge that this individualized, clinical conceptualization presents is that in many post-conflict settings, most, if not all, members of the population have been exposed to (often multiple) forms of trauma,[4] and many will suffer acute symptoms of stress. The sheer size of the exposed populations worldwide creates an insurmountable challenge if the objective is to provide most survivors with direct counseling or other forms of psychiatric attention. Torture survivors alone constitute a large grouping, with that form of abuse being practiced in 111 nations, either by government authorities or by non-state actors such as militia, warlords, or insurgency groups.[9] Regional wars are ubiquitous, prolonged, and intractable, with mass rape, abduction, summary executions, and enslavement of children as soldiers, each being endemic features of such conflicts.[9] Over 14 million refugees are displaced to other countries, most commonly bordering states in the developing world that have few resources available to provide care or protection for exiled communities.[10] Almost an equal number of persons are displaced by violence within the borders of their own country, making them inaccessible to humanitarian assistance or protection from international bodies, such as the United Nations, whose mandate is limited to refugees who cross national borders.

Mental Health Needs Resulting from Mass Trauma

The extent of exposure to mass trauma, and the limited resources available to low-income countries in which most of these conflicts occur, create major obstacles to providing psychological assistance to any more than a small minority of survivors.[4] The dilemma is that several epidemiological studies undertaken in the last decade have indicated high levels of traumatic stress reactions in these populations. Pooled data from relevant studies indicate that the rate of various traumatic stress disorders amongst refugees and war-affected populations range from 15 to 47%, with a study in Sierra Leone being exceptional in reporting a PTSD prevalence of 99%.[11–15] The rates of depression also are high, often approaching 50%. In comparison, the rates of PTSD in civilian settings in developed countries, such as Australia and the United States, range from 1.3% to 8%.[16,17] The practical relevance of these epidemiological findings amongst war-affected societies has been challenged, however, by ethnographic inquiries, such as one undertaken in a post-war Angolan village.[8] That investigation suggested that traditional communities regard grief and stress as shared, normative experiences, that indigenous counseling approaches are effective in dealing with such problems, and that therapies introduced by outsiders would be regarded as alien and intrusive.

Hence, in assessing the actual extent of the need for external mental health interventions in such settings, and the types of assistance that would be useful, a clearer distinction must be made between normative communal reactions to stress and individual, trauma-related psychiatric disturbances that, unless treated, will lead to chronic disability.[4] A related question is the extent to which repair of the social environment, the primary focus of humanitarian relief operations, itself can facilitate psychological recovery, thereby limiting the need for direct clinical interventions.

The Trajectory of Post-traumatic Stress Disorders in Refugees

There is growing recognition that after trauma exposure, symptoms of stress in the acute phase are common, that most resolve spontaneously,[18] and that excessive professional intervention, such as indiscriminate debriefing, is unwarranted and may even be counter-productive.[19] Reactions such as insomnia, hypervigilance, autonomic arousal, and avoidance of threat cues are likely to represent evolutionary defensive reactions that confer protection against further threat. Clearly, in low-income countries, professional intervention for these acute reactions is neither feasible nor desirable, particularly given limits in resources, logistics, and skills.

Is it possible then to reconcile the apparently epidemic rates of traumatic stress disorder reported by epidemiological studies with a pragmatic approach to communal recovery? Most epidemiological studies have been undertaken in

settings of ongoing insecurity, for example in refugee camps or in societies that continue to face low-grade warfare.[11,12,15] When studied, the communities continued to suffer insecurities that would perpetuate existing traumatic stress reactions. A critical issue, therefore, is how trauma-affected refugees adapt when social conditions have been stabilized sufficiently to relieve communities of such stresses.[20]

Longer-term, follow-up studies of refugees living in stable resettlement environments are relatively scant, but the few investigations that have been undertaken reveal a tendency towards sound adaptation and recovery.[20] Two studies undertaken amongst Southeast Asian refugees in North America stand out in that they have undertaken serial mental health assessments during a 10-year period. In a study that followed a cohort of Hmong refugees, Westermeyer and colleagues found that psychological stress scores improved substantially during the 10 years.[21] In a longitudinal study of Indochinese refugees undertaken in Canada, Beiser and coworkers recorded a stepwise reduction in psychiatric symptoms over time. Although levels of psychiatric distress were high in refugees early after resettlement, 10 years later, the rates fell to below that of the host population.[22]

This study involved a retrospective analysis of the course of post-traumatic affective disorder amongst 1,100 Vietnamese living in the state of New South Wales, Australia.[23] The epidemiological sampling approach and the diagnostic measure used (the Composite International Diagnostic Instrument) allowed direct comparison with an Australia-wide epidemiological survey of over 10,000 households conducted two years earlier.[24] In addition, a Vietnamese measure of distress derived from culturally-derived idioms of mental illness and calibrated according to indigenous diagnoses made by traditional healers was included.

Overall, the Vietnamese community showed remarkably low levels of anxiety, depression, and PTSD (aggregated 12 month prevalence of 8%) compared to those of the host population (18%).[24] The interaction of trauma severity and the time since the trauma occurred predicted current psychiatric status. Vietnamese exposed to one or two major traumatic events showed high levels of initial symptoms, but 10 years later, the prevalence of mental disturbance in that group was no greater than amongst compatriots not exposed to trauma. Those with extreme levels of trauma (three or more major traumatic events) had a very high prevalence of mental disorder in the early years, but they too showed progressive improvement over the ensuing 10 years, although there remained a residual subgroup with chronic affective disturbances. Overall, the study suggested that the Vietnamese had adapted well to their new lives in Australia, with the majority being free of mental disturbance in spite of high levels of pre-migration trauma exposure.

Predictors of Outcome of PTSD and Other Stress Disorders

Increasingly, research amongst refugees has identified risk and protective factors that influence the psychological outcomes associated with exposure to trauma. These factors include not only the nature and quantum of the trauma, but also individual vulnerabilities and strengths, the type of traumatic stress reactions experienced, social and cultural influences, and the impact of policy on the recovery environment. The latter influence has assumed particular salience given major shifts in global policies on refugees.[25]

The aforementioned Vietnamese study illustrates the positive outcomes that can be achieved when refugee groups are offered optimal resettlement conditions. Although there was some controversy about the acceptance of Vietnamese boat people in the 1970s and 1980s by Australians, this public concern soon abated, and the newcomers were granted permanent residency and access to all public services, as well as to educational and work opportunities. The sound adaptation of this group may be attributed at least in part, to the positive recovery and resettlement environment they were offered in the Australian context.

In contrast, commencing in the 1990s, policies of restriction and deterrence have been imposed on asylum-seekers arriving in Australia and other developed countries.[25] A series of studies undertaken amongst these more recently arrived asylum-seekers living in the community and in detentions paints a picture of persisting and disabling post-traumatic stress symptoms.[26,27] Consistent with early refugee studies, these more recent investigations confirmed that previous exposure to trauma was a major risk factor for chronic PTSD, depression, and other indices of psychosocial impairment in asylum-seekers.[26,27] In addition, however, post-migration stresses were found to compound such effects.[28] Most of these ongoing stresses are the direct consequence of restrictive administrative policies applied to asylum-seekers, including: (1) uncertain or temporary residency status; (2) threats of forced repatriation; (3) problematic interactions with immigration officers; (4) administrative barriers to obtaining work permits; (5) inadequate access to social and health services, and to education and financial support; and (6) obstacles to reunion with family living in other countries.[25,27]

Thus, global immigration policies emerge as powerful factors influencing the trajectory of post-traumatic stress reactions in refugees. Where displaced persons are offered a welcoming environment and the opportunity to participate freely in the host society, most will recover from traumatic stress reactions over time. Where administrative obstacles are placed in their path, stress reactions will be perpetuated and lead to longer-term disability.[27]

Diversity of Outcomes

Difficulties remain for clinicians, however, in predicting, with sufficient precision, during the early post-traumatic phase, which refugees will experience persisting and disabling traumatic stress reactions that will not remit naturally. In considering this issue, it is important to note that the PTSD is not the only reaction to trauma experienced by displaced groups. The traumas suffered by refugees are multiple and complex in their meanings, and as a result, elicit a range of adaptive or maladaptive responses.[4] Apart

from the PTSD, refugees may manifest depression, anxiety, somatization, drug and alcohol abuse, attacks of anger, and a range of maladaptive changes in social behaviors.

The nature of the trauma itself may determine to some extent, the type of psychological response. In a sample of Bosnian refugees resettled in Australia, Momartin and colleagues have shown distinctive reaction patterns to specific domains of trauma and stress. Life threat was uniquely associated with the risk of PTSD, whereas traumatic loss of close family was linked specifically to complicated grief and depression.[30]

Which pattern of psychological response is most likely to lead to persisting disability is important for identifying those refugees needing priority attention. Although there is ample evidence that the PTSD is associated with social dysfunction in Western societies,[17] similar evidence obtained from refugee populations is relatively scarce. Recently, however, Mollica and colleagues have shown that co-morbid PTSD and depression, a common clinical presentation, is a particularly disabling response pattern in Bosnian refugees, with rates of psychosocial dysfunction in the co-morbid group being five times greater than amongst psychiatrically normal compatriots.[12] That study was undertaken in a refugee camp in the immediate aftermath of the Bosnian conflict.

Our group found the identical pattern of disability amongst Bosnian refugees resettled for an average of five years in Sydney, with those suffering co-morbid PTSD and depression showing five times the levels of dysfunction compared to non-affected compatriots.[30] Those exposed to the combined traumas of life threat and traumatic loss were at greatest risk of co-morbidity.

These observations suggest that certain types of complex trauma may leave deep psychological traces on the survivor. Amongst Bosnians, for example, it was common for survivors to report being threatened with death while forced to witness the brutal murder of family members, an experience that seems to have long-lasting impacts, possibly because of the inevitable shame, survivor guilt, and self-recrimination that persist in the aftermath. Such findings suggest a need to define more clearly the complex interactions linking types of trauma, the contextual, cultural, cognitive, and social mechanisms that mediate these experiences, and the ongoing influence of the post-traumatic environment, in efforts to target more accurately those refugees at greatest risk for persisting psychosocial disability.

Principles Guiding Psychosocial Interventions

A realistic response to the psychosocial needs of refugees must be based on the assumption that most will not have access to individual counseling or psychiatric interventions. The corollary, therefore, is that where direct clinical services are provided, careful thought must be given to the target group that receives priority attention. Priorities may differ according to the context in which refugees are treated. For most survivors, however, repair of the social fabric is the key to facilitating natural recovery from acute stress reactions.[4]

The model proposed herein reinforces the principle that even under conditions of adversity such as forced displacement, communities will make strenuous efforts to re-establish five core adaptive systems that together restore coherence to the collective.[4] These hypothetical systems of adaptation include: (1) the re-establishment of safety and security; (2) the restoration of interpersonal bonds; (3) the creation of systems of justice; (4) the development of a social framework that allows survivors to develop new roles and identities; and (5) the revival of institutions that confer meaning, whether political, social, religious, or spiritual.

Effective humanitarian interventions aim to facilitate these self-restorative tendencies.[4] Such programs provide strategic protection for the most vulnerable by offering short-term, life-sustaining support (food, water, shelter, medical care); create mechanisms to reunite families and kinship groups, or, for those who are bereaved, facilitate traditional grieving rituals; restore effective systems of justice that address past and ongoing human rights violations; encourage the establishment of new roles (work, leadership, training); and assist in re-establishing places of worship, systems of democratic governance and other institutions that encourage expression of previously unfulfilled political, social, religious, and spiritual aspirations.

How these reconstruction processes are pursued and how effective they are, will depend on the resources, context, culture, and historical background of the affected society. In all settings, success depends on transferring leadership from international agencies to the indigenous community as soon as it is feasible, in order to reverse the history of dependency and passivity created by the preceding years of oppression.

Mental health professionals do not lead larger-scale humanitarian programs, but can contribute to them by providing advice and consultancy to policy-makers, planners, and program leaders. Where appropriate, specific and carefully designed psychosocial projects led by mental health personnel may be strategic in advancing the larger processes of social recovery. For example, in societies in which traditional grieving practices have been disrupted, psychological advice might be sought to foster the restoration of culturally-appropriate mechanisms for overcoming traumatic losses.[4] Psychological support may be helpful to those participating in truth and reconciliation processes, war crimes tribunals, or the identification of human remains exhumed from mass graves. Multidisciplinary approaches with mental health input also may assist in the psychosocial protection and support of vulnerable groups such as single mothers, unaccompanied minors, and the elderly.

In all instances, mental health inputs into these broader processes should be pursued with pragmatism and constraint, given the limited evidence-base available to guide such work. In particular, practitioners should avoid making excessive claims about the power of psychological interventions on their own to remedy complex problems such as inter-group enmities, mass violence, and social responses to human rights violations. Attention to contextual, cultural, and historical issues is essential in order to engage, build

trust, and forge partnerships with local workers, who should be encouraged to assume leadership in projects as their capacity to do so is developed. In general, small psychosocial projects should be favored that have clear and achievable objectives and a sustained and measurable impact on the recovery process, in contrast to ambitious, wide-ranging programs with poorly defined targets, and, as a consequence, whose impacts are difficult to gauge.

Intervention Programs in Low-Income, Post-Conflict Countries: The Case of East Timor

As indicated, limitations in resources and skills in low-income settings where most refugees are located, make it imperative that clinical services focus on the most needy of the population, since only a small minority can be offered direct treatment. In such settings, the problems of underdevelopment, poverty, and lack of services compound the effects of trauma and persecution.[2] Facilities to treat the mentally ill are primitive or non-existent, and there may be few or no trained mental health professionals available to initiate services. During the upheavals in Central Africa, Cambodia, East Timor, and other regions, the severely mentally ill were at risk of abandonment, violence, or abuse.[2] Reports from mental institutions in Kosovo and Iraq have reinforced the concern that in times of chaos, psychiatric inmates are at risk of gross abuses including rape, assault and eviction.

Our own experience in initiating a psychosocial recovery program in East Timor underlines these points. Prior to our involvement in the home country, the team, led by the Psychiatry Research and Teaching Unit, University of New South Wales, and the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) in Sydney, had provided community-based services to East Timorese asylum-seekers living in Australia.[5,31] The focus largely was on traumatic stress reactions and post-migration stresses arising from the prolonged process of seeking refugee status.

After the mass destruction and displacement of populations that overtook East Timor in the wake of the referendum on independence in 1999, a consortium of Australian agencies formed PRADET (Psychosocial Recovery and Development in East Timor).[5] We recognized that years of underdevelopment followed by wide-scale destruction had left the emerging nation without functioning health services of any kind. No mental health professionals had been trained in East Timor, and there were no dedicated mental health facilities or psychiatric drugs available.[32]

For these reasons, we focused on two broad levels of intervention. The first was to contribute to the overall recovery program by offering consultancy, training, awareness- raising, and assistance in health policy formulation. Aware that we could not offer direct services to all those with the PTSD and related disorders, our small clinical program based on two expatriate workers, visiting psychiatrists, and 15 East Timorese trainees, focused specifically on those persons whose psychological problems were of such a nature as to compromise their capacity to survive in a chaotic environment. Patients referred in the early period after the emergency often had behaved in violent or chaotic ways, were at risk of abuse or constraint (for example, by being chained to trees), or were unable to care for themselves in environments in which survival challenges were extreme.[5] Hence, instead of focusing primarily on those who had suffered trauma, or on specific diagnostic or demographic subgroups, priority treatment was directed at persons (and their families) facing the most extreme social risk. By adopting a crisis focus, the activities of mental health services converged with those of the overall humanitarian mission in that we aimed to ensure the survival and adaptation of a vulnerable group that no other agencies were capable of assisting effectively. The range of diagnoses was wide and included psychosis, traumatic stress reactions, organic brain disorders including epilepsy, and culturally-based stress reactions. Interventions included psychiatric assessments and review, counseling, family support and education, referral for social support from other non-governmental organizations, prescribing of medication, and referral to health clinics for co-morbid physical disorders.

These practical experiences highlight the need for a more pragmatic epidemiology for mental health research in post-conflict settings. Instead of enumerating common, stress-related disorders, future research needs to focus more on the social consequences of mental disturbance in order to identify the subgroup at greatest risk of adverse outcomes if they are denied emergency treatment.

Refugee Torture and Trauma Services in Developed Countries

In more stable environments, such as in resettlement countries of the West, clinical programs can focus on more specific subgroups of refugees and asylum-seekers, especially in settings in which generic mental health services are available to treat common psychiatric problems such as psychosis. Specialized torture and trauma rehabilitation services provide early intervention programs that screen for psychiatric and physical needs on arrival, and provide short-term counseling, as well as longer-term psychiatric and psychotherapeutic interventions for the minority with severe traumatic stress responses.[33] In addition, services commonly pursue strategic community development activities that assist refugee groups to integrate into the wider society, while liaising with a network of agencies that offer a range of other services such as language classes, advice on finances, as well as assistance with accommodation, employment, and educational opportunities.[33]

Even then, however, existing services in technologically advanced recipient countries continue to face new challenges, especially those created by evolving government policies in relation to asylum-seekers.[25] Assisting authorized refugees who have permanent residency to overcome past trauma and resettlement stresses differs substantially from the task of aiding asylum-seekers held in detention who face the threat of forced repatriation to countries where they have previously experienced torture and other forms of oppression.[26,27] As yet, models of intervention for this latter group have not been clearly formulated, although

there is a growing consensus that standard treatments such as cognitive behavioral therapy are unlikely to be effective unless key issues of justice and existential despair are incorporated into the therapy. Therapists inevitably become advocates, providing supportive documentation to represent refugee claims, while trying in more general ways to shift government policies that clearly impact adversely on the mental health of asylum-seekers.[26,27] It is inevitable that asylum-seekers only will respond favorably to therapists who adopt an unambiguous position in supporting their rights, an important ethical and practical consideration when mental health professionals consider taking up positions in government institutions such as asylum detention centers.

As indicated, optimal assistance to persons displaced by mass violence and human rights violations requires that any therapeutic intervention takes place in an eco-social setting that actively remediates the conditions of injustice that survivors have experienced.[4] Where elements of those injustices are perpetuated, for example, by the prolonged detention of asylum-seekers in countries in which they seek sanctuary, then it is inevitable that the impact of direct therapeutic interventions will be attenuated.[26,27]

Discussion and Conclusions

As indicated, most refugees and persons exposed to mass violence live in settings of poverty in low-income countries. Funding and skills to provide health services are severely constrained in such environments and mental health often receives low priority given the urgency of other health needs. For mental health to gain ground in such settings, professionals in the field must build a consensus about priorities and approaches. In this article, I have attempted to indicate the need for a more pragmatic focus on issues of social survival and adaptation. Traumatic stress reactions are common in post-conflict settings, but most are short-lived and self-correcting. Supporting the reconstruction of social institutions that encourage survival and adaptation provides a platform for individuals and their collectives to mobilize their own natural capacities for recovery. Mental health personnel can play an instrumental but not a lead role in multidisciplinary efforts to achieve this broader humanitarian mission.

Where clinical services are initiated, a clearer analysis of priorities is required. In low-income, post-conflict settings, urgency of social need provides a more realistic criterion for intervention than an exclusive focus on trauma, on particular psychiatric disorders, or on demographic subgroupings. Those at extreme social risk manifest a wide range of mental disturbances including psychosis, severe post-traumatic stress reactions, neuro-organic conditions including epilepsy, and culturally determined stress reactions. In developed countries in which a range of services exist for the severely mentally ill and where refugee groups form a minority, dedicated torture and trauma services can focus specifically on the early detection of traumatic stress reactions and on programs that assist with acculturation and resettlement.

At a global level, professionals working with refugees in the mental health arena are faced with formidable challenges.[20] Mental health issues are poorly understood both by helping agencies and affected communities, interventions often are undervalued, and controversy amongst professionals about priorities tends to undermine advocacy for services. These challenges are occurring at a time when shifts in global policies on refugees are creating new public health problems by perpetuating the stresses and threats that these vulnerable communities already have endured.[20] The need for concerned mental health professionals to work collaboratively at a global level to address these problems never has been more urgent. Excessive divisions about the focus or value of mental health interventions for refugee and post-conflict populations only can further disadvantage a group already at risk of neglect and abuse.

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