UNIVERSITY OF CALIFORNIA, BERKELEY

School of Social Welfare
120 Haviland Hall MC 7400
Berkeley, CA 94720-7400
TEL: (510) 642-3949
FAX: (510) 526-7964
E-MAIL: spsegal@berkeley.edu

Mental Health and Social Conflict

Violent social conflict is a public health problem (WHO, 2002). Collective violence escalates mortality and morbidity in conflict-affected populations, 90% of which are civilians including vulnerable children, women and people belonging to socially oppressed groups (McDonald, 2010). The World Report on Violence and Health estimated that deaths caused by war were310,000 in 2000 although the incidence would increase if it included war-related violence in traumatized populations (Mollica et al., 2004; WHO, 2002). Violent conflict also engenders tremendous psychological as well as physical injuries and increases the burden of disease associated with negative mental health outcomes (Baingana, Bannon, Thomas, 2005; Scholte et al., 2004). According to the Global Burden of Disease study, the burden of mental health and behavioral disorders is estimated to increase from 12 percent in 1990 to 15 percent in 2020 even as violent conflicts shift from the 16th to the 8th leading cause of disease (De Jong, 2002).

Mental health problems are pervasive in conflict settings although often considered invisible (Mollica, 2000). As a consequence of systematic and/or targeted violence such as genocide, torture, and gender-based violence, people in conflict settings are exposed to enormous psychological trauma and tend to experience multiple adversities and losses often accompanied with forced displacement. Pervasive violence and insecurity deteriorate social and economic conditions and impede access to basic needs including foods, shelter, healthcare, education, and physical safety, which become risk factors for poor mental health. Hardships and abysmal conditions caused by forced migration tend to exacerbate or precipitate mental health problems, while family loss and/or separation commonly associated with forced migration is likely to cause immense psychological distress and grief-related problems (Mollica, et al., 1993; De Jong, et al., 2000; Pumariega, et al., 2005).

Conflict-affected populations thus demonstrate higher incidence rates of common mental disorders such as post-traumatic stress disorder (PTSD), major depression disorder (MDD), mood disorders and dissociation than populations in non-conflict settings (Porter & Haslam, 2005; Carlson & Rosser-Hogan, 1991; Steel, Silove, Phan, & Bauman, 2002; Kinzie et al., 1990). A systematic research review revealed that 4% to 86% of refugees experience PTSD and 5% to 31% meet criteria for depression (Hollifield et al., 2002). A substantial number of refugee children report MDD in other studies, ranging between 11% and 47% of the samples studied (Servan-Schreiber et al., 1998; Weine et al., 1995; Heptinstall, Sethna, & Taylor, 2004). Other psychological symptoms pervasive in post-conflict societies include, but are not limited to, somatic symptoms, sleep disturbances, hypervigilance, and incident-specific fears (De Jong, 2007; Baingana, et al., 2005; Ursano, 2002). Substance abuse and behavioral disorders are also

widespread in conflict-affected populations (Karam & Ghosn, 2003; Silove, Ekblad and Mollica 2000).

Despite convincing evidence of a strong association between trauma and risk of mental disabilities, the lack of adequate mental health assessment and referrals obstructs accurate estimation of the mental health status of conflict-affected populations (Lustig et al., 2004; De Jong, Scholte, Koeter, & Harte, 2000; Pumariega, Rothe, & Pumariega, 2005). Conflict-affected low- and middle-income countries (LMICs), in particular, face challenges in assessing mental disorders and providing accurate epidemiological data, resulting in a paucity of baseline data, considerable variance in prevalence estimates, and thus inadequate epidemiological figures (Hollifield et al., 2002; Summerfield, 2000; Mollica et al., 2004).

It is also the case in many armed-conflict countries that social infrastructures for healthcare are weak or absent (WHO, 2007). Social catastrophe results in damage to de facto systems, economic development, and social infrastructure, and thus not only exacerbates mental health but also delays services for mental health (Mollica et al, 2004; Saxena, Thornicroft, Knapp, & Whiteford, 2007). Capacity of mental health service and psychosocial interventions is often limited (Salive, 2005). Resources are sparse or inaccessible in conflict-affected countries and thus health and mental health services as well as community resources for psychosocial needs are not available not only before but also during and after conflict situations and humanitarian emergencies. Mental health service and psychosocial interventions are in increasing demand in humanitarian aid to restore conflict-affected communities.