EDITORIAL

Mass trauma and mental health in Africa

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Considerable recent evidence points to the perniciously deleterious effects of war- trauma on the mental health of affected individuals, families or communities[1]. These effects cause massive complex humanitarian and health emergencies which may span generations with significant negative impacts on the public health and socio-economic development of affected societies[2]. Most western studies of war-related post-traumatic stress disorders (PTSD) have been in exiled refugees or combat veterans with only a few addressing the plight of those who stayed behind in their communities[3]. Mollica has described considerable psychiatric disability in those massively traumatised communities who stayed behind in their countries of war - trauma, as was on the Thailand – Cambodia border[4] and in the former Yugoslav republics[5]. In Africa, in a study of treated war-traumatised survivors, Musisi, described significant psychiatric disability in survivors of war living within their own country[6]. In all these studies, the most common disorders were PTSD, depression, anxiety, and problems in coping with life from day to day. Various workers have described the psychiatric evaluation and treatment of massively traumatised individuals such as war-refugees or earthquake victims[7]. Such studies are rare in Africa.

Rice and Summerfield among others pointed out the dilemma of the recent phenomena paused by the so-called "low-intensity" warfare which is aimed at destabilising populations and causes more civilian causalities than in combatants[8,9]. These wars abound in Africa. Such wars have characterised most recent warfare than was the case in conventional armies of the past causing much civilian causality. Indeed recent reports estimate the number of civilian causalities of such war-related mass trauma to number in the millions worldwide[1,8,9.] These wars have dominated the war- scene since the end of World War II and have proliferated more after the end of the cold war, with consequent massive population displacements, refugeeship, epidemics and significant human suffering[1,8,9]. Yehuda and Danieli have described the trans-generational effects of such severe traumatisation[10,2]. Lastly, the phenomenon of gender-based sexual violence directed to women, as a weapon of war, has been noticed to increase in recent wars as was seen in Bosnia[5] and Rwanda[11]. The long-term mental health fall-out of such traumatisation and its public health implications has yet to be fully investigated worldwide, especially in Africa. Some workers have also reported on the public health sequelae of mass trauma including epidemics, e.g, HIV/AIDS and ebola, which have followed warpaths in many parts of Africa.

Some workers have cautioned against the "medicalisation" of what they see as normative human response to extreme adversity as happens in war. However, most studies of mass trauma point to a core set of mental health symptoms in traumatised individuals but which symptoms may lend themselves to varied expressions in different cultural settings[12, 6]. These symptoms centre on the concept of the diagnostic categories of PTSD, depression and anxiety disorders including panic anxiety and phobias as well described in DSM IV-TR[13]. In Africa we also see various forms of dissociative and somatoform disorders in massively traumatised individuals thus giving credence to the concept of "culture-bound PTSD syndromes". Recent evidence points to demonstrable neurobiological changes in the brains of individuals with PTSD such as hippocampal atrophy, amygdaloidal hypersensitivity or Hypothalamic – Pituitary – Adrenal Axis dysfunction thus giving neuro-biological correlation to the effects of psycho-traumatisation[10]. Co morbidity is common and often, there are other associated psychological problems such as substance abuse, personality changes and general psychosocial dysfunction in the life after trauma of affected individuals [10,13]. These symptoms respond to a variety of treatments including psychopharmacologic, psychotherapeutic and behavioural approaches as well as social support[10,6,7]. However, the effects may be lifelong and the secondary effects may span generations[2]. Both impact on the mental and public health

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of communities and the eventual socio-economic development of societies as well as to the mass psycho-social behaviour of communities e.g. increases in domestic violence, child abuse, substance abuse or the tendency to use militarism resolve all forms of conflict even at interpersonal level[1].

Many communities, especially in Africa, Asia and the Middle East continue to be afflicted by chronic war-conflicts with massive traumatisation of their populace[1,3,4]. However, there is very limited information on the mental health consequences of such mass trauma on African communities in particular nor on attempts to treatment or on the governance of intervention strategies[6,14]. Worldwide, three main approaches have been employed in the study of severe mass trauma. The first approach involves interviewing representative samples of a given community in a defined Epidemiological Catchment Area, ECA. Such studies yield very limited data as not everybody in the ECA has been confronted by the traumatic event(s). Nevertheless such studies give us the prevalence rates of PTSD and associated disorders in the general population. The second approach is to interview the actually traumatised population at risk of developing PTSD after trauma exposure e.g. war, combat or refugees in IDP-camps. Such studies yield significant information about the effect of mass trauma on the affected communities but they are often limited by the timing of the study in relationship to when the actual traumatisation occurred. Lastly are the individual case studies of traumatised individuals e.g. in a trauma treatment clinic. Such studies give us information about the effects of trauma on an individual and have enabled us to delineate the syndromatic concept of PTSD[13]. However these latter studies don't give much epidemiological data, as do the population studies.

In Africa, there seems to be a general lack of public awareness or knowledge about the mental health consequences of either mass trauma or its impact on the public heath of communities even at official levels. There is neither general public awareness nor political appreciation of the root and /or global causes or associations of the chronic warfares that abound in Africa; or of efforts at conflict resolution/prevention apart from military action and political appeasement of combatants. Discussions with a few intellectuals including doctors, politicians and academics, reveals the role of international trade in small arms and the international struggle to control Africa's resources (minerals and oil) as the real reasons for the endemic destabilisation of Africa's populations. As well, the recent surges in nationalism and religious fundamentalism seem to have replaced the old East versus West ideological struggles of the cold war era. Some also sight ethnic rivalries in the struggle for control of economic resources and territory and the divisive colonial boundaries[15].

The extent to which African countries acting alone or individually to solve the huge problems of mass trauma is very limited. Universal literacy, human rights education and drives to transparent electoral democratic governance at all levels of public life have been stated by many as the would be ideal preventative means through which to achieve sustainable peace and development as well as mental health stability. However, for the presently traumatised populations, efforts at decentralised mental health care through an integrated Primary Health Care approach is deemed most practical, appropriate, affordable and achievable. This calls for appropriate training of primary mental health counsellors, and all health care providers in the awareness, recognition and management of problems of mass trauma and their associations. These treatment approaches would involve culturally, gender and age sensitive psychotherapeutic approaches, social support and affordable medications where indicated. Community (as opposed to individual) redress through the construction of infrastructure, roads, clean water, power, health centres, housing, schools and viable small economic projects and vocational skills training would help reconstruct communities. In the immediate aftermath of trauma, rescue and relief operations and crisis intervention are inevitable. These call for disaster preparedness on the part of governments and international relief organisations. Lastly there has to be built in plans for the care of caregivers who often suffer burn out and exhaustion when dealing with the massively traumatised. One must also not forget the resilience of individuals and communities in dealing with trauma and this calls for recognition of the traditional, individual and community coping skills and resources which are often neglected by international professional helpers, yet they form the basis of **"best practices**".

In conclusion, extensive literature now exists documenting the deleterious effects of mass trauma including its mental health effects on individuals, families and communities. However, conflicts and wars continue, especially in Africa. Research on conflict prevention and peace sustenance is needed in order to address the public and mental health consequences of mass trauma. Secondly policy needs to be put in place regarding the governance of mental health care in post-conflict societies. Such policy is lacking at both local and international level and this must

precede legislation to be put in place to avoid the chaos of non-governance of services as happens in most conflict ridden societies. Lastly the concept of "Best practices/Best strategies" should be inherent in all conflict interventions. All these should be linked to the final goal of economic development, good public and mental health, good democratic governance, building social capital and finally sustained respect to human rights and human dignity. Mass traumatisation bedevils Africa today and African masses suffer both the short and long term negative consequences. It behoves all African scholars, and health workers in particular, to research and publicise the causes, effects and sequels of mass trauma on our peoples and to find appropriate solutions both for prevention and treatment These are the areas in need of extensive research by researchers possessing trans-cultural and trans-disciplinary competence. In this regard, Karunakara's study of traumatic events and symptoms of post-traumatic stress disorder among Sudanese refugees, nationals and Ugandans in Sudan and Uganda, published today in *African Health Sciences* is a welcome addition to the scanty African literature on this very important subject[16].

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