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The Hidden Epidemic: Mental Health Epidemiology in Post-Conflict Populations and Implications for Conflict Transformation Practices

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Peacebuilding and Conflict Transformation
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ACRONYMS

BCRHHR – The Boston Center for Refugee Health & Human Rights

FGM – Female Genital Mutiliation

GAD – General Anxiety Disorder

MDD – Major Depressive Disorder

OB/GYN – Obstetrics and Gynecology

PTSD – Post-Traumatic Stress Disorder

SIT – School for International Training

TBI – Traumatic Brain Injury

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ABSTRACT

This capstone explores the ramifications of unmitigated mental health illness in conflict populations, paying special attention to refugees and migrants. The intersection between conflict and mental health is explored and analyzed in order to highlight the implications of the findings and to make recommendations to both metal health and conflict transformation practitioners. This capstone depends predominately on secondary resources and personal interviews and is informed by my own practicum experience at a refugee health center. The need to improve mental health outcomes in order to pursue conflict transformation and peace building is a key focus and is supported by the research pursued by this capstone. This capstone closes with a call to action, elucidating the importance of practicing in a multidisciplinary fashion, marrying conflict transformation practice and mental health practice, to cater to the refugee crisis in Syria.

INTRODUCTION

Today we are witness to what is being called the worst refugee crisis since World War II. In 2014, the UNHCR reported that approximately 42,500 individuals fled their homes in a desperate attempt to escape violent conflict. That figure does not represent an annual average; it represents a *daily* average. By June 2015, the UNHCR averaged the total to 60 million displaced individuals (UNHCR; 2015); this is equivalent to the population of Italy**.** At this time, Syria is the greatest producer of refugees and displaced peoples with an estimated 12 million having fled their homes since the outbreak of civil war in March 2011 (USAID; 2015). Of those displaced approximately 650 Syrians have been admitted as refugees in the United States (Jordan; 2015).

At the Boston Center for Refugee Health & Human Rights (BCRHHR), the site at which I pursued my practicum and now currently work, we see approximately 350 clients per year, representing just over 90 countries (BCRHHR; 2015). Of those clients, perhaps only 2% are Syrian. The primary service the Center offers is that of outpatient mental health; most clients pursue therapy and psychopharmacological intervention. Of these clients, 84% have experienced torture (primary survivors of torture) in some capacity and 11% have been vicariously traumatized- typically defined as a transformation of self that results from empathetic engagement with traumatized populations; it disrupts spirituality, ways of thinking, character and perceived meaning; also called a secondary survivors of torture - due to their close familial relationship (BCRHHR;2015). Torture, in this context, constitutes a large range of physical and mental practices, implemented with the intent of doing harm or physical or emotional pain. Though torture or the experience of torture can be experienced as an effect without intent, this particular population was specifically

targeted due to sexual orientation, political activism, ethnicity and/or gender. Both groups, primary and secondary, can present as symptomatic and may have been diagnosed with a mental health disorder. The most common diagnoses include PTSD (Post-Traumatic Stress Disorder), MDD (Major Depressive Disorder), GAD (General Anxiety Disorder) and psychotic disorders (I will be using psychotic disorders as an umbrella for psychiatric illnesses that cause a severe or abnormal change in thinking and perceptions, ie.: schizoaffective disorder, psychosis, and bipolar disorder.). For the ease and purposes of this paper, I will be referring predominately to these four categories of mental illness. Though I am unable to disclose the percentage of patients who have been diagnosed with a mental health disorder at our clinic, I can report on national averages and confirm that what we see agrees with the research: the incidence of mental health disorders in refugee and asylum seeking populations is high (Gojer; 2014). It is also important to understand, for the context of this paper, that this includes both those who have experienced direct violence and those who have experience migratory trauma[1] which refers to those who have been forced to flee but may have not experienced any direct violence.; one does not have to be exposed to the horrors of torture, to witness death, or receive a conflict-related injury to experience psychological decline. In these populations one may find a mental health diagnosis of 40%-100% of population, depending on the point of care, resettled area and conflict from which the population fled (Gojer; 2014, NAMI; 2011, Mills; 2005).

My point is this: the number of clients we have seen at the center is extremely small; in fact it is statistically insignificant in comparison to the worldwide population. If

[1] This typically refers to those who have been forced to flee but may have not experienced any direct violence.

the rates of mental illness in this population are so high and such a small sampling of refugees and asylum seekers are receiving care, what does this mean on a global scale? This question has become more present in my mind and practice as we continue to see the deterioration of the current Syrian refugee crisis, and as the Center continues to receive referrals and walk-ins[2] on a daily basis. I seek to explore the implications of this question, pursuing the very real short and long-term effects that the refugee experience has on the psyche of an individual and the community, as well as the impact they have on peace building processes.

BACKGROUND

My reasons for pursuing this question stems not only from a personal interest and the desire to more deeply explore and understand my practicum experience, but to also educate practitioners of conflict transformation on the very real effects trauma has on the brain and one's ability to process and pursue self-actualization and recovery. During my studies at SIT trauma was discussed very often and it was fundamental to acknowledge its existence in order to pursue deeper conflict analysis. However, my practicum experience, as well as years of work in the medical field, has also forced me to confront the realities of trauma and its psychological sequelae. Trauma does not end with the experience and carries very real weight throughout one's lifetime. It can fundamentally change a person and though many frames within conflict transformation acknowledge and teach this truth, I seek to inspire practitioners to not only be mindful of the realities of trauma, but to consider practicing in a deeply trauma informed manner, or to find a point of collaboration with mental heath resources.

[2] Individuals who come to the Center without previous referral; they have, in a literal sense, walked in from the street seeking assistance.

My tertiary purpose is to make a call to action. I will briefly explore the potential of integrating mental health into transformative pursuits, as well as explore the concept on a moral ground. One of the most important this I have learned whilst pursuing my studies at SIT is the importance of practicing radical empathy. The refugee crisis is heartbreaking on a very fundamental level as it, to me, represents an incredible disparity found in the human experience. I marvel at the sheer numbers of refugees and, if tallied, what that suffering and fear, would amount to. Sixty million displaced people. That is a lot no matter how one views it. However, when the economic lens is removed, or the political lens and instead adopt an empathetic lens – a *human* lens – what one might see is *not* sixty million mouths to feed, or sixty million in need of jobs; it is sixty million people who are afraid, uncertain, depressed, losing hope … this is not just one of the worst refugee crisis in recent history; it is far more than that. If we do not more actively research and realize the effects conflict has on the general mental health of a population, or make the call for a more trauma informed practiced, we are facing a situation that has the potential to be, in my opinion, one of the worst modern day mental health crises that has ever been seen on a global scale.

OVERVIEW

Now that I have established my reasoning for pursuing this question, I will now impart a brief overview of this capstone. I will first review the methodology, in great brevity, and introduce key concepts in conflict theory and conflict epidemiology in order to solidify the foundation necessary to most fully gain from the work pursued by this capstone. After a brief forward, I will move onto the 'meat' of this capstone exploring the question by first analyzing the mental health impacts of conflict on refugees as individuals. I start

with the individual experience and build towards community aspects, creating steppingstones to the larger picture. After exploring mental health impacts on the community level I move on to the implications these concepts have on practice, both within the disciplines of conflict transformation and practitioners of healthcare. This portion of my capstone is meant to not only assist in my own conceptualization of the ideas and models learned in order to improve my practice, but to offer a space for others to expand their own thinking and perceptions of these concepts and to, perhaps, assist others in their own implementation of these ideas, should it be pertinent and desirable. Finally, I will close with my own personal call to action and the conclusion of this capstone.

METHODOLOGY

This capstone is intended to provide a space to contextualize my practicum experience and to more deeply explore topics introduced in the course Theory and Practice of Peacebuilding and Conflict Transformation. It also serves to enrich my understanding of the field of public health, one of which I have long been a part of and one I intend to continue to pursue.

I will be depending heavily on utilizing relevant secondary sources in order to support my theories and analysis of certain occurrence seen in epidemiology and within conflict as a broad spectrum, most notably as it effects refugees. These resources include public data, scholarly articles, media resources, and news articles that speak to, with the highest degree of credibility, issues relevant to this capstone. I also utilize learnings acquired from discourse with a select few clinicians with BCRHHR. This collection of qualitative and quantitative data has been utilized to inform the analysis of the manner by

which conflict and public health intersect, and to provide a foundational understanding of both conflict and public health theory. I hope to build a salient and compelling case for the integration of mental health practices in conflict transformation practices, founded on historical and current events.

OVERVIEW OF KEY CONCEPTS

Conflict Theory

The analysis will depend on basic conflict theory concepts but will draw heavily on specific theories. Much of this analysis is informed by *basic human needs theory,* specifically concepts postulated by Abraham Maslow and Johann Galtung. From Maslow I will be utilizing Maslow's hierarchy of needs, which consists of five 'motivational' needs, depicted in hierarchy (Figure 1). This model posits that human needs are arranged in a hierarchy and that certain needs are 'higher' than others; I will utilize this model to discuss concepts within mental health epidemiology (Maslow; 1954) as Maslow's hierarchy of needs is often used in mental health to offer comparative analysis and to better understand disorder and the manner by which it manifests and disseminates. Galtung's work (1980) will more heavily inform this discussion and it should be understood that when human needs are discussed it draws from his approach (from this point onwards, referred to as 'the basic human needs approach'). The key points to understand for the following analysis are, a) unmet needs are harmful to the individual, b) the pursuit of needs does not have a definite end, needs are constant and evolving, c) needs are not something that can be traded (a need can't be fulfilled by sacrificing another need), and d) that one of the needs is that of identity, a need that can be forgotten amidst violent conflict and after (Galtung; 1980). Finally, Volkan's (2004) theories on

identity will be utilized to discuss mental health and cognitive development in conflict. Volkan will be utilized to discus`s identity formation in both individuals and communities; his theories will be discussed in detail later in this work. I will be referring to these concepts throughout this capstone and offer this introduction to offer a basic understanding of these concepts are they are not only utilized within my own analysis of the intersections of mental health and conflict, but exist within public health modalities and social work.

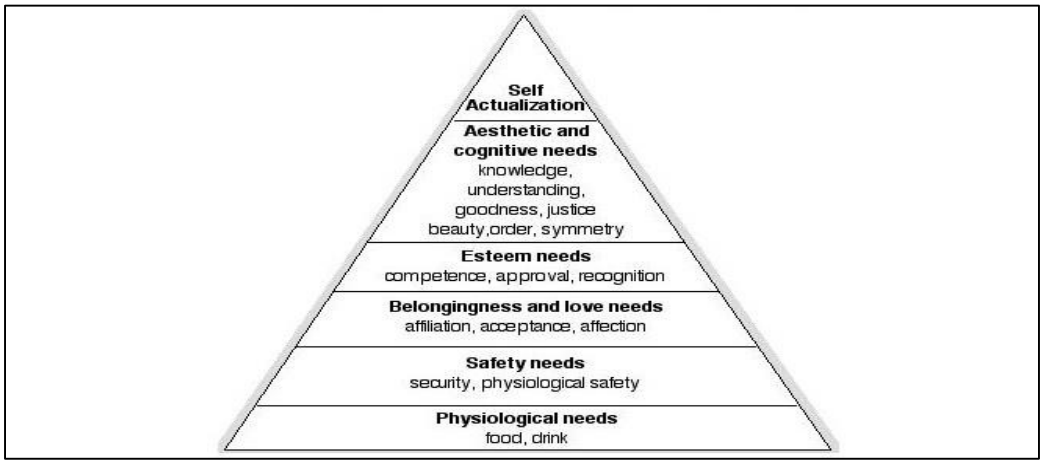

FIGURE I: MASLOW'S HIERARCHY OF NEEDS

Intersections of Conflict and Public Health.

In order to understand the short and long term burdens of unmitigated mental health crises have on refugee populations, we must briefly explore the way by which conflict theory and epidemiology intersect and interact. Conflict, especially violent conflict, is closely associated with suffering, displacement, structural instability, economic failure, loss of security – the list is endless but never the same for any given conflict. What is important to understand, in regards to the intersection for health and conflict, is what is

required for a public health crisis to take hold. One need not to look to far into the past to gather greater understanding of the definition of a public health crisis; the Ebola epidemic that spanned 2013 to 2015 in Western Africa is a good example as it not only encompassed a large population, spreading across boarders and effectively halted and dismantled certain infrastructures and drastically effected the norms of every day life. Such a crisis is rather dependent on the illness (not all illnesses are created equal; the host, vector, expression of symptoms and virulence is a major influence), but poor health typically arises from polluted environments, high population density, lack of medical care, lack of proper sanitation, pre-existing illness or suffering, and generally poor conditions, often enough resembling squalor. These are the conditions produced by conflict and conversely, a health crisis; this is a very brief explanation but it is true and simple. Conflict breeds situations by which epidemics and poor health thrive, and poor health can perpetuate and inspire conflict via long term socioeconomic effects, fear of fighting an unseen enemy and loss of resources and capacity (Howard; 2012).

RESEARCH BASED ANALYSIS: FORWARD

As explained in *methodology*, the analysis of the ramifications of unmitigated mental health crises in refugee populations will be explored via an expansive review of current research along with interviews performed with clinicians at BCRHHR. The following topics are those that I have outlined to be the most pertinent to the current atmosphere and the most inclusive; however they are by no means the only symptoms or results of greater mental health crises in the world's populations displaced by conflict.

MENTAL HEALTH IMPACTS OF CONFLICT ON INDIVIDUAL REFUGEES

Immediate and Short Term Mental Health Concerns in Refugee Populations

I must preface this section drawing attention to the fact that 'short term' is a bit of a misnomer and has a very specific meaning in this context. Here, 'short term' is used to describe the immediate consequences of conflict on mental health and conditions in the refugee experience that are considered 'temporary'.

When viewing the refugee experience from a basic human needs perspective, satisfiers of needs are typically woefully unavailable and the tools by which to pursue them are inadequate or absent. For many in flight, the most basic human needs – food, shelter, water - are barely attainable. From a mental health perspective, lack of security is perhaps one of the most pertinent and worrisome of unmet needs in nearly any population (Cummings; 1996). This is because of the role security plays in emotional resiliency, the cornerstone for mental health wellness and recovery. The refugee experience is rife with personal and communal insecurity, along with the aforementioned unmet needs. These combined adversities place monumental stress on one's ability to cope (Thomas; 2011) and with compromised coping mechanisms, the more severe and destructive affects of mental health diaspora, such as suicidal ideation and schizophrenia, are likely to become more prominent (Matheson; 2008). We can see this concept reflected in today's Syrian refugee crisis, most notably amongst children. In a 2014 study pursued in a refugee camp in Lebanon, nearly 41% of refugees aged between 15 and 24 had contemplated suicide (Shaheen; 2014). Along Syrian borders, the International Mercy Corps found that around 31% of refugees had severe emotional disorders and 10% suffered from schizophrenia

(Leigh; 2014). This illustrates the severe effect conflict has on the mental health of populations suffering from mass displacement secondary to conflict.

As mentioned earlier in this capstone, the conflict and trauma does not end with the direct violence or direct experience. Once in the camps, though perceived safety may increase, there are still dangers, some more prevalent than others. Unfortunately, these refugee camps are not immune to violence and sexual assault (Lischer; 2005, Greenwood; 2013) and most camps are distressingly low on supplies and resources, let alone widespread and comprehensive mental health services. In one interview published by *The Atlantic*, a surgeon in a Syrian refugee camp remarked that even within the camp, after the violence, "everything here is psychological trauma (Gordon; 2013)." It is important to value mental health resources in the immediate response to such crises and conflict. One must not assume, even in the overwhelming aftermath, that the end of violence is the end of trauma; rather, it is the beginning. There is a reason PTSD is so aptly named; this describes a symptomatic period that occurs *after* the trauma. For some, the physical battle for survival is over, however, the battle for their own mental wellness is at its beginning. A response that does not heed those needs is likely to experience obstacles in the long term.

Long Term Mental Health Concerns in Refugees

For many refugees and asylum seekers, mental health issues or symptoms secondary to psychological stress may not appear until after the 'flight' stage is over; in some the resettlement stage offers elevated risks because it is typically the time in which one can process their traumas and see their own personal disruption (Murray; 2013) The resettlement stage also tends to see more highly traumatized individuals at risk of

developing psychological disorders, such as psychosis and MDD (Steel; 2002). There is also a direct correlation between the severity of mental health illness and the amount of time the individual has gone without intervention or treatment. Though some individuals will experience a decline of symptoms over time, many will experience psychological ramifications that are chronic or permanent (Steel; 2002). The data collected at BCRHHR agrees with these trends and for many, mental health illness isn't realized or fully comprehended (and in some cases, accepted) until their personal or familial security – security of those considered family, blood or otherwise - has been realized; that is to say, flight has ended, or direct violence is no longer being experienced and has been distanced enough from the individual to process on a deeper level. When looking at mental health recovery in this population, there seems to be a very direct correlation between met needs and mental health recovery, especially in regards to safety. It is understood in the mental health practice that increased feelings of safety are what allow recovery (Mollica; 2011) and one of the primary purposes and goals of resettlement is to ensure safety and feelings of personal security. In many cases, once the individual has begun to rebuild their sense of security and has begun to meet their most basic human needs (and not all manage to do so, even after resettlement), needs associated with belonging, esteem and self-actualization become more visible and pursuable, following Maslow's hierarchy. It is important to understand, however, that during and after exposure to violence, it is possible – and in some contexts common – for those 'higher hierarchy' needs to be met, even as physiological needs and safety are unmet (MacDonald; 2011).

What I wish to point out through this exploration of mental through the basic human needs lens is how deeply dismantled one's identity can become during the refugee

experience. A refugee may lose many aspects of their identity during the actual event or crisis. Resettlement adds yet *another* identity or obstacles to react to, further complicating the already intricate recovery process and identity building process.

To contextualize, I offer the brief story of a woman seen at BCRHHR. In 2013 she was an accomplished West African lawyer, a mother of a school-aged boy, a homeowner, and recently matriculated in a PhD program at Makerere University. Today she is between homes, separated from her child, jobless, and burdened with psychological trauma. Though she is safe she feels like a 'weight' in her community, unable to contribute fully, and she knows she will never completely recover from her depression and PTSD until she is reunited with her child. Clients like this *do* make progress, however, because of their professed inability to meet a certain need, they are – to some extent - unable to make a *full* recovery.

What I am attempting to highlight, in regards to long-term concerns is that the presence/absence of adequate satisfiers of unmet basic human needs satisfiers and mental health recovery/decline have a direct effect on one another (Young Foundation; 2013). Populations, such as refugees and asylum seekers, are at especially high risk for experiencing multiple unmet needs. When compounded and unmet over long periods of time, something seen consistently in individuals and communities with trauma, one might expect to see a reduced ability to make choices and to act autonomously, and decreased or restricted capacity to feel competent and worthy (Young Foundation; 2013). From both a mental health and conflict transformation perceptive, this has the potential to be devastating to the individual and the community to which they belong; I will elaborate on

these implications later in this capstone.

MENTAL HEALTH IMPACTS OF UNMITIGATED PSYCHIATRIC DISORDER ON COMMUNITIES & SOCIAL INFRASTRUCTURE

Economic Impact

Though it is undeniable that mental illness can have a profound effect on the economic and social functioning, the way by which the two interact are extremely complex and not always clear, especially with the endless number of factors that may be unique to a particular context. Generally, the effects of lingering psychological disability on social and economic behavior are "obviously subtle and difficult to separate out from the complex of motivations and circumstances that shape human behavior (Muscat; 2011)."

The most obvious and direct correlation seems to be the general decrease in functionality that is seen in mental illness, particularly in job and social performance (BU-CPR; 2015). A society that is suffering from any kind epidemic is susceptible to a decrease in the capacity for productivity (Howard; 2012). Those with PTSD, GAD and MDD are more likely to stay at home, rather than work, or find themselves struggling to participate in society in general (Muscat; 2011). In the refugee and post-conflict context there are several obstacles that may compound upon this pre-existing loss in functionality; many are facing legal, access, and linguistic barriers. This may translate into lost work hours, a prolonged 'burden' to taxpayers and government assistance programs, and general monetary loss as the individual(s) are unable to economically contribute (Howard; 2012). Though it may take time for the ramifications to be truly realized, on a macroeconomic scale, unmitigated health crises (and conflict) threaten

economic health and stability. It is for this reasons I believe in developing mental health services in resettled populations and approaching resettlement in a holistic manner. As the refuge crisis continues it is important to understand that trauma experienced on a mass scale "moves the problem of mental health beyond the confines of the health system per se, into the mainstream of factors affecting overall post-conflict recovery (Muscat; 2011)." This speaks to post-conflict recovery in both individuals and communities, resettled populations and populations in the region of 'resolved' conflict. This is particularly important to understand when considering refugee populations; recalling the high rates of PTSD, MDD and other mental health disorders, along with the record high number of refugees, the potential for the refugee crisis (especially the Syrian crisis) to impact local and global economies is too great to ignore.

Studies show that "a good portion of a total post-conflict population will be able to adapt and cope well, as individuals, if the post-conflict environment is secure and experiencing economic recovery (Muscat; 2011)." When resettlement efforts manage to address the basic human needs, develop resources for coping, and offer job assistance and training, the individual is more likely to improve their functionality, lessening their personal negative economic impact. I have seen this in my own work at BCRHHR and it is by this reasoning and understanding of human needs and the effects of trauma that 'holistic' treatment is sought. It recognizes that human's are made up of a system of complex needs and that they need to be pursued in a fashion as harmoniously as possible in order to achieve greater healing. This is of course, a simplification of the issue; many of the world's worst conflicts are still revealing the manners by which the economy will be affected and mental health has not been so deeply studied. In time, we will come to

better understand how mental health – specifically mental health – affects global and micro economies.

Social & Community Impact

In the post-conflict settling, immediate medical attention is often lacking and resources are stretched thin (Muscat; 2011); this is especially true of mental health services and is a common issue in refugee resettlement (Asgary; 2011). Barriers to healthcare, in the post-conflict or refugee setting, include: a) internal and personal issues (mistrust, underlying mental illness, and fatalism), b) structural issues (lack of services, lack of linguistic and capacity), and, c) issues in social assimilation (navigation of health system) (Asgary; 2011).

Though the epidemiology of mental health has received less attention than infectious disease and more physical maladies, current research shows deep communal and societal impact. The post-conflict context is rather fascinating in that it acts as a catalyst, producing mass mental illness without prior history within the population or individual (Asgary; 2011). Unlike general mental health epidemiology, which typically traces illness to daily stresses, childhood abuse, and family dysfunction, conflict mental health epidemiology typically traces origins to deep fear and emotional trauma, cultural collapse, loss of trust and repeat betrayals (Asgary; 2011). This is not to say that these traumas exist separately form each other; the human experience, prior to conflict, remains and no trauma can be measured greater or lesser than another. What is to truly be noted here, is that the mental health ramifications of large scale, far reaching traumas – again, as seen in war and conflict – inspire and have the ability to induce mental health illness on a large scale. One might argue that the same can be said about these aforementioned

'daily' traumas, that society as a whole suffers from its own range of mental illnesses, expressed in our daily troubles and violence. However, what I wish to point out is not the uniqueness of conflict and war related trauma, rather, the opposite. Across cultures and across contexts the manifestation is the same; it bleeds across gender, borders, generations – it has the ability to catalyze existing traumas to ascend into heightened states and inspires new trauma in those that have never experienced it. It can appear remarkably uniform in its epidemiology, the only requirement being the trauma of war and conflict. These traumas, according to BCRHHR clinician Fernando Ona, act as catalysts for drastic changes in families and communities (Ona; 2015). These changes can be beneficial, or harmful; typically, in the immediate post-conflict setting, these changes are the latter. With mass unmitigated mental health crises, the psychiatric stage has also been set for the development of dependency issues (Ona; 2015). In this context, dependency is defined as reliance on a person, item or behavior, as a facilitator or vector of coping that may appear benign but is, in the long term, potentially destructive. Dependency, from the mental health recovery perspective, can be a very destructive crutch for one's recovery. Speaking from a more macro lens, especially within post-war development, dependency extends past individual recovery and into community development and governance. Such dependency, whether on the individual or the governmental level, can worsen already weakened behaviors or structures (Onken; 2002).

Vicarious or secondary traumatization is also a deep concern within post-conflict and refugee populations. This means that unhealed trauma can be handed down to

children and grandchildren ad infinitum, until the experience is adequately[3] addressed. Herein lies the danger of unmitigated mental illness or unaddressed trauma in individuals and societies; just as it is seen within conflict – the handing down of mourning, grief, war, disagreement, for example, - mental illness and instability, too, can be transferred to family and future generations (Fromm; 2012). One does not have to experience trauma first hand to experience PTSD, MDD, or behavioral disorders; secondary survivors – or those experiencing the transfer or trauma/transgenerational trauma – can be diagnosed and show symptoms as though they have experienced the trauma as a primary survivor. Clinician Kathleen Flinton (2015) highlighted the fact that the children of refugees and asylum seekers are particularly at risk and are extremely susceptible to the nuances of behaviors secondary to trauma (Flinton; 2015). Vicarious and secondary trauma is not relegated to family. Trauma and its psychological sequelae can spread throughout communities, the most commonly used example of this phenomenon is mass hysteria. It is important to understand that it does not spread in the traditional epidemiological sense. The vectors, by which it travels –rather than parasites, fluids, or aerosolized, - are conditions of conflict, such as failed infrastructure, violence, and poverty. The emotional states produced by those stressors can create a cycle in which the negative emotions or behaviors are perpetuated leading to increased numbers of mental illness. It is not to say that mental illness is transmittable in a transitional sense. What is meant here is that when imagining an atmosphere, or setting, that chronically dehumanizes and subjugates, it gives rise to the conditions in which one's personal mental health may become compromised or fails. Constant experienced violence and aggression, for example, may

[3] The definition of 'adequate' will vary per individual and can consist of a multitude of requirements.

create a situation in which attitudinal and behavioral disorder is likely to develop. It is inherently important to understand that mental health disorder is not relegated to images of depression ad PTSD, but also social and behavioral disorder. For example, general anxiety disorder is one that, when dominating an environment, may be 'passed on' by those empathetically involved; this concept is most noted between child and parents (Woodruff-Borden; 2002). It is not to say it is destined that all in such an environment will too suffer, rather, it highlights that mental illness, especially in its extremes, has transferable qualities and can be pervasive when one is under stress.

Recent studies have also suggested that the pre-disposition to the translation of trauma into mental health illness – PTSD, MDD, and GAD., - is *genetically* transferable, that the way we respond to trauma, the way we cope, and our susceptibility to PTSD and MDD in very early childhood, is partly a product of our genetic makeup (Meaney; 2005, Yehuda; 2015). These studies have pursued deeper understanding of the manner by which the body reacts to stress on a hormonal level. In the simplest terms, what was discovered was that the hormones and receptors responsible for the interruption of the stress response are, possibly, genetically transferable traits. In summation, unmitigated mental health illness not only has an infectious property in nature at its extremes, but it may, to some extent, transcend generations, passing down a pre-disposition. Looking at the whole picture, one can at least see how damaging high stress related traumas can be when viewed holistically from genetic, physiological, psychological, and social perspectives. This has, in my opinion, strong implications for post-war development, resettlement, and peacebuilding efforts.

Impact on Identity & Psychological Development

Identity is typically defined as the way of being; it is the way one thinks about oneself and the way by which the world views that person in turn. Identity is what informs the by which one pursue life; is designs and builds ways to react and to cope, the way by which comfort is fought and security defined. Identity develops in stages, and is known as 'core identity formation; this is complicated process that begins in the first month of a child's life and, over time, solidifies into a sense of self (Volkan; 2004). This is important to understand as it highlights the significance of the experiences held in early childhood. Looking at the process - split into three stages for greater theoretical discussion- the effect conflict and trauma may have on a child's identity is clear. The identification stage, for example, involves development of a sense of self by essentially adopting traits and functions of significant people in their lives (Volkan; 2004). If a child is raised by violence, or by anxiety, the child is likely to adopt traits of this variety[4]. This is a very prominent intersection of mental health and conflict as, "repeated exposure to chronic and traumatic stress during development leaves children with mental and related physical ill-health, notably PTSD and severe personality changes (Schauer; 2010 p. 311)." Because this stress has taken place in a developmental period, it has become part of their identity, part of their person. Children who are so thoroughly traumatized at a young age are very difficult to rehabilitate and often require very consistent, long-term psychological treatment (Schauer; 2010). For many, 'full-functionality' will never be a possibility due to the fact that the developmental period has passed and neurologically the individual has matured.

[4] For a more thorough discussion on this topic, see section: *Youth and Growing Up with PTSD, MDD & GAD.*

Throughout our lives we face a plethora of formative experiences that shape and change our identities; one such experience is trauma. Trauma and conflict create stressors to our identities, challenging their shape and existence. According to Volkan (2010), changing 'subgroup' identities – perhaps a professional identity, or an identity focused around a hobby – is relatively easy and can be done so without a great deal of anxiety. When looking at displaced populations, this is especially obvious. However, when the 'large group identity' – ethnicity, tribe, or culture – is threatened, as is seen in conflict and magnified in displacement, populations will undergo great care to stabilize it (p 49). This 'large group identity' involves 'seven threads', which describe reactions these groups have to their threatened identity. Among them are chosen glories and traumas; these mental representations of glorious events that have elevated the populations and terrible events that have left the population feeling victimized (Volkan; 2004). These are typically passed transgenerationally; from a medical perspective, this passing down of trauma is akin to vicarious traumatization and closely resembles coping behaviors seen in populations with unmitigated PTSD and MDD (Daud; 2005). Research confirms that the forced alteration of identities, secondary to a traumatic experience, is a catalyst of mental illness and that the transaction between identity, conflict and mental health is very present in modern day conflict and displacement.

IMPLICATIONS FOR CONFLICT TRANSFORMATION & PEACEBUILDING

Mental Health in Post-War Development: The initial aftermath of acute crises are often wrought with confusion, distress, fear, and an overwhelming amount of differing needs. It is understandably difficult to focus on needs that go beyond the most basic –

food, water, shelter – and resources are often lacking. It is no surprise that mental health needs are forgotten or delayed., or fail to be recognized. However, this period of time is an important and effective catalyst for the improvement of health systems. If health, especially mental health, systems are built in the 'early recovery' period, it is more likely that they will become institutionalized and will persevere through the hardships of the developmental period (Howard; 2012). In contrast, if health is not implemented into the development period, it will prove far more difficult to develop sustained practices and models that are ble to adequately cater to the health needs of the community.

Limitations to Trauma Healing Due to Decreased Neurological Capacity: In post-conflict settings, and in populations that have experienced both physical and psychiatric traumas, it is not uncommon to see temporary, intermittent and chronic neurological dysfunction. Mental illnesses such as PTSD, and MDD, when secondary to psychological trauma[5], have high correlation to the development of neurobiological abnormalities (Sherin; 2011). The same is found in regards to traumatic brain injuries; TBI are often more severe and complex as they involve direct damage to tissue and encompass a variety of issues that wouldn't be seen in abnormalities secondary to psychological trauma. TBI are a concern in many post-conflict populations as head injuries are one of the most common injuries suffered as a result of conflict and violence (Keatley; 2013). The sort of abnormalities one might expect secondary to PTSD, MDD or TBI are biologically complex and involve a direct alteration of the manner by which the brain functions; this translates into a dramatic shift in the ability to process, cope, and function. This is extremely important to understand, as what this suggests is that some individuals

[5] PTSD or MDD that is due to psychological trauma, such as torture or rape, rather than injury to the brain.

who have experience a psychological trauma with be *biologically* and *physically* incapable of healing from trauma while suffering from PTSD. For example, research suggests that PTSD and MDD have a direct effect on hippocampal volume (Sherin; 2011); hippocampal capacity/volume is responsible for stress responses. The responses are better known as 'fight or flight', and represents the physical response to something stressful or 'exciting'. This is the racing heart in face of danger sensation, the sudden sense of focus or, inversely, the foggy minded 'frozen in place' reaction. These symptoms are highly associated – when the stress is triggered too often and sometimes by something that isn't indeed threatening – with panic attacks and anxiety disorder. Thus, what this translates into is the compromised ability to handle stress and the neurobiological inability to "turn off" a stress response (leading to these aforementioned panic attacks). Effectively, it is possible for those with MDD and PTSD to become unable to discriminate between past and present stressors, or distinguish a safe environment from a threatening one, leading to GAD and behaviors indicative of such a diagnosis (withdrawal from social interaction, or disassociation).

This is incredibly important to understand as a practitioner and when pursuing conflict transformation, as one might encounter a population or individual who is physically incapable of healing or coping. This is not the sort of individual who might be able to thrive in a post-conflict, developmental period and would require special attention. It is also not someone I would recommend for the deep exploration of a conflict, or someone who may benefit from mediation. It is not to say they are not in need of such transformative work; rather, it is to suggest that placing them into a situation,

which may produce triggers, or may induce stress, could be harmful to their recovery and psyche.

This concept also highlights the possibility that many individuals might recover or address their trauma in a very delayed, or slow fashion. I believe it is important to practice mindful of the obstacles clients may be facing and building an awareness of the neurobiological effects of psychological and physical trauma may help inform that work.

Youth and Growing Up with PTSD, MDD & GAD: One of my greatest shifts in awareness that I gained from my time at SIT was my new understanding of the importance the youth play in the recovery of a society; they are especially important in conflict transformation endeavors as they represent the future of the community. This has helped shift some of my focus on the importance of focusing on both the youth and their caretakers in regards to developing programming for improved functioning and mental wellness. One of my greatest concerns in regards to post-conflict societies – and especially refugee populations – is the handling of the youth and the early intervention of trauma.

As mentioned earlier in this capstone, suicidal ideation in Syrian youths is alarmingly high. For a child to recognize their suffering as an inescapable and incurable condition is a terrible indicator for the general wellness of that population and bodes poorly for long term outcomes; it is also tragic to imagine that a child has the capacity to contemplate death and the willingness to die, and possibly pursue it. Youth populations are in need of special intervention and care as childhood 'adversity' leads to increased risk to develop conditions such as PTSD and MDD (Sherin; 2011) – conditions that are likely to continue well into adulthood – and the inability to fully develop psychologically.

In a post-war development setting, or in a resettled setting, this has incredibly huge implications. In 2013, more than 50% of Syrian refugees were younger than 17 and 38% were younger than 11 (Chalabi; 2013). When facotring in the typical ramifications of long term conflict, such as loss or destabilization of infrastructure, it is easy to imagine how far behind many children will fall in regards to their social development, education, and personal growth. Add mental health compromise and there exists a population that is overburdened and extremely vulnerable. This is the population that will grow to be community and societal leaders; without intervention and proper resources, this population may grow up, en masse, to be less educated and with more trauma than previous generations. Poor education and poor mental health are terrible indicators for recovery; without the development of resilient models and informed care/practice, one risks a population that grows *into* their mental illness and trauma rather than *out* of it.

Mental Illness & Influences on Perceptions of Resolution & Capacity for Peacebuilding: Compromised mental health in combination with unmet needs may have a great transformative effect not only on function and behavior, but perception. This concept exists within basic human need theory, suggesting that when an individual has many unmet needs they are likely to aggress. For some, the way by which one reacts to unmet needs might be extremely atypical of their behavior. All people experience this in some capacity. Perhaps financial stress manifests in anger in a way never before experienced, or the birth of a first child inspires feelings of agoraphobia with anticipatory anxiety. Behavior change secondary to stress is not uncommon, however, it can be worrisome with great changes in personality and cognition. It is especially worrisome if it affects the ability to cope. When looking at post-conflict populations, especially migrant

populations, "recent studies, which have examined the prevalence of psychological effects after conflict, suggest that traumatic exposure and resultant symptoms of PTSD and depression can influence how individuals perceive mechanisms aimed at promoting justice and reconciliation (Schauer; 2010)." This suggests a neurobiological change; a change that is hard to reverse without intervention. In many cases intervention would include therapy and the possible use of psychopharmaceuticals. With low access to either and high stigma attached to both, these individuals may be permanently altered by their trauma, unable to fully pursue reconciliation in a manner that may have, at some point, been more natural to them. Furthermore, "PTSD severely impedes processes of reconciliation and reintegration: war survivors exposed to war-related trauma displayed stronger emotional responses to perceived impunity, including anger, rage, distress, and desire for revenge … (Basoglu; 2005)." This suggests that not only do perceptions change, they are more likely to change in a manner that is negative and non-conducive to deeper healing. I do not intend to say that only negative perceptions can arise from conflict, rather I wish to bring attention to the capacity for mental health illnesses to affect one's perceptions which may, in turn, affect reconciliation efforts.

IMPLICATIONS FOR PRACTITIONERS

Clinical & Mental Health Practitioners

One of the most apparent obstacles I noticed in my practicum experience was the significant improvement in effectiveness of psychosocial support that medical professionals' increased knowledge in conflict theory should be able to generate.

Studying conflict and conflict resolution theory may supplement a practitioner's understanding of a particular barrier or issue in a patient's life or in the pursuit of their

care. In traditional medicine, especially western, there seems to be a monopoly on the definitions of health and illness. For an individual with a different cultural, linguistic, or ethnic background pursuing public health issues or patient care within the lens of conflict may assist in the broadening of one's clinical toolbox. Just as some practitioners may pursue work that is 'trauma-informed', work that is 'conflict-informed'. Conflict informed work wouldn't, in my opinion, require a deep understanding of a specific conflict – though it might help when serving a specific population – but would draw on a more developed sense of empathy, and a more prominent awareness of alternative lived experiences of others. In the medical field it is already difficult to find a practitioner who might be able to offer more than 15-minutes. During my practicum experience I assisted with the intake process – the process of accepting a new client into care; this process typically includes the menu of services, initial PTSD and MDD scales, and the collection of trauma history for - several refugee and asylum-seeking clients. Typically, it took 10-15 minutes to be connected to an on-phone interpreter. The intake alone would take about an hour and the subsequent work with the clinician would take anywhere from 2-3 hours. This appointment may not reveal the depths of physical or psychological needs, and if this specialized care cannot delve deeply into trauma history within hours of care, how can any practitioner do this in the industry standard of fifteen minutes? With increasing quota needs in hospitals and clinical settings, insurance mandated protocols (such as mandatory 'to be asked' questions during a clinical encounter), and the general increase in the patient to physician ratio, clinicians have less and less time to work with their clients. This is particularly difficult and troubling for populations like refugees, many of whom face an already large range of obstacles in their pursuit of care.

Though practitioners typically cannot change the amount of time they have, they can change their approach. Being conflict-informed suggests the practitioner has a deeper understanding of the obstacles the patient may be facing in regards to their health, whether it is physical, social, psychological, or other. As mentioned earlier, it relies heavily on empathy and enforces a practice that is more flexible in its approach, more informed and privy to the individual's *experience* as a whole, not just medically.

Conflict Informed Practice and Trauma Specialists: Though it was mentioned earlier that I do not believe it completely necessary for one to understand conflict from a historical or analytical perspective, I do believe it has a place and that is, at certain points, the responsibility of a clinician to explore. In OB/GYN practice, for example, the clinician is working in a context in which the client may have experienced sexual assault or trauma. By understanding the conflict, a practitioner may be able to more adeptly guide the client through their care by also offering an understanding and competent dialogue surrounding the trauma. In 2013 approximately 32% of women seen at BCRHHR (2015) had experienced sexual violence and typically sought care to address and assist with pregnancy, termination, sexual disease, and FGM reversal/restoration. Considering the likelihood of mental disturbance or illness, it becomes more clear the amount of care and attention a client from a marginalized population or form a traumatic background, would require. It is for this reason that I think it would be both within the practice of a clinician and within reason to pursue deeper understanding of a specific conflict; being able to offer informed understanding may make a world of difference to a client who is going through such a delicate and life altering experience.

Conflict Resolution Skills: Dismantling Clinician and Patient Barriers: My final point

focuses around the skills typically associated with practitioners of conflict resolution. In many patient settings the patient often feels an imbalance of power; this individual may become despondent in their health seeking behavior or may be afraid to speak their mind regarding their own health. This is an even greater issue in marginalized populations – especially migrant populations - as differing cultural, medical and social practices may put the client in a place of perceived inferiority; migrant populations may also have the added weight of fear regarding their immigration status and will not speak out in order to avoid unwanted attention. By practicing better communication skills, derived from conflict resolution frameworks, practitioners can create a collaborative relationship rather than one that more closely resembles a compromise or a command. In populations with trauma this is particularly important, as it will help build trust and is more likely to develop a deeper interest in one's health; it also offers greater insight into the perceived needs of the individual, something that is very lacking in health care. In my experience, it is also rather empowering to the patient to be seen as someone with knowledge and valued perspective in regards to their health.

By pursuing this deeper form of communication and by implemented conflict analysis into practice, I believe clinicians will be able to more easily transcend the barriers that come with such populations and will create an environment in which the client is not only more compliant but is ultimately empowered. I deeply believe this would improve health outcomes for all populations, not just those at risk.

Having worked in the mental health field with refugees and asylum seekers, I can offer suggestions that may improve practice and inspire deeper communication and understanding clinician to client and, if need be, client to client. One particular tool

utilized by clinicians at BCRHHR is that of performing background research on the conflict from which the client fled. Clinicians utilize this information to more effectively map the clients experience and own understanding – and future transformation – of their experiences and trauma. This technique is especially utilized in group therapy with clients who come from similar conflict backgrounds, or have experienced a specific trauma (technique of torture, for instance). One such group is a Ugandan LGBT group that focuses on the conflict as was experience by each client, paired with visual interpretations of the experiences. This helps 'generalize' the trauma and develop the sense that the client is not alone in their trauma, and weren't alone during the time of conflict. BCRHHR, in particular, encourages the study of conflict and is deeply educated on conflicts old and new.

I would recommend that those seeking medical practice with populations post-conflict should implement into their clinical training and continuing education, exploration of conflict analysis and conflict theory utilizing case studies that reflect the work of such a practitioner. Such practice will better prepare clinicians for the realities that come with post-conflict work.

I offer my own personal response in identification of the need for improved communication between patients-clinicians and patients-patients. Developing a health literacy program may be beneficial to patients seeking to better understand mental health and the healthcare system and may identify needs unknown to clinicians. If it is within the capacity of the practitioner or program, developing a conflict resolution skills program or group may also offer a space to better meet the needs of all parties involved in the treatment plan. Such a course is being developed at BCRHHR and will be

implemented in order to break down communicative barriers, to facilitate healing and offer a safe space to develop coping mechanisms. Such workshops may prove useful in practice and may be indicated if the need is high.

Developing Cultural Competency: Naturally, when seeking to work with immigrant populations, specifically refugee populations, one must acknowledge the existence of cultural, linguistic, or ideological differences that may affect the delivery of care. One such difference is that of fundamentally different understandings of what 'health' means. For many, western medicine may seem an abstract concept and it is not unreasonable to anticipate resistance, a lack of understanding regarding health modalities and an unawareness of health needs. In many cultures, mental health is still deeply steeped in stigma; as we see at BCRHHR, initial fear, resistance or doubt regarding mental health is common, or at the very least, anticipated. I have worked to respond to this obstacle to care by developing and implementing health literacy workshops, meant to empower clients and offer the knowledge needed to navigate the American healthcare system and take control of their own health. Such interventions have assisted in breaking down client-clinician barriers, have increased appointment attendance and have helped improved social functioning.

Conflict Transformation Practitioners

As mentioned earlier in this capstone, it was important for me to express the significance of trauma and mental health informed practice or to consider utilizing mental health resources in conjunction with conflict transformation practice. Practitioners of conflict transformation take on an incredible responsibility and I truly believe such knowledge and resources will benefit the conflict-affected communities and individuals, as well as the practitioner.

Deepening Practice in the Field & Increasing Personal Safety: Personal and communal health are cornerstones of any society. One must remember another adage: 'if you don't have your health, you have nothing at all.' Without wellness, one isn't free to pursue the fullness of life due to physical, spiritual and/or psychological limitation. For practitioners of conflict transformation and peace building, it is important to understand all aspects of a population; the health of the said population is very important and relevant. I believe that any additional information is valuable, even if it doesn't seem pertinent at the time. For some, healing from trauma and conflict involves reconciling with health issues that are secondary to that trauma. For example, working with a client who lived through violent conflict and was sexually assaulted. After becoming ill and being examined they find that they are HIV positive. It is possible that a significant part of the healing and personal transformation of the trauma requires concurrent medical care, along with the support of someone who understands both the psychological and physical consequences and can respond accordingly. This is most likely an example that is, unfortunately, common in today's refugee crisis and is an expected atrocity of war. Utilizing public health resources, especially those of the psychological variety, will help create a more comprehensive and clear picture of the conflict, the population and the individual. I am a deep believer in the multidisciplinary approach – an approach that 'mobilizes a cross-section of scholars and activists' (Arai; 2013) – and see great potential for the marriage of public health and conflict transformation.

Increasing one's depth of understanding will also, invariably, improve one's security. The more knowledge obtained, the more power one has to make for safe and cautious practice. This is not to say that every practitioner is facing definite danger, but

building awareness around the realities and sequelae of trauma will allow a practitioner to build spaces that value safety. Though most mental illnesses are not known to cause or create violent behavior, PTSD and Psychotic episodes can result in behavior that may inadvertently injure the individual or others within the vicinity. Having witnessed a violent flashback episode in my own practice, I believe such an event is a realistic possibility in the sensitive work pursued by conflict transformation practitioners and that practitioners would benefit from studying the psychological and physiological effects of trauma.

Increasing Awareness of Vicarious Trauma and Developing Good Self Care: Conflict transformation practitioners are, depending on the practice, exposed to great amounts of trauma, and like any professional who is exposed to such, the chances of becoming vicariously traumatized is increased. Increasing awareness and understanding of vicarious trauma, is vital, however some of the most important aspects to draw from mental health practice are good coping mechanisms and self care practices. I often think of the old adage, 'physician, heal thyself'. This, in my opinion, applies to all who decide to take on the trauma and suffering of others. In order to do this work, which requires great empathy and sympathy, one must remember what they teach and practice: patience, love, empathy – all the great emotional makings of resilience and forgiveness. The practitioner must treat oneself with kindness and care, and must know when to take time and space for personal recovery.

In one study that focused on the vicarious trauma experienced by practitioners along the Gaza Strip, it was found that there exists a direct relationship between the presence/severity of PTSD and MDD, and a practitioner's exposure primary trauma

(Finkelstein; 2015). Practitioners that didn't experience primary trauma – exposure to night raids, rocket attacks, and increased need for vigilance - were, naturally, less likely to develop severe PTSD or MDD. However, those that did experience trauma were able to reduce symptoms by seeking respite, increasing personal connections, improving professional self-efficacy and seeking reliable support systems (Finkelstein; 2015). I believe this is an important point to highlight for conflict practitioners, especially those in the field. Unlike most mental health professionals, practitioners of conflict resolution and peacebuilding often find themselves in the thick of the action or the conflict. Whether working on Palestinian-Israeli relations near the Gaza Strip, or on police brutality in St. Louis, or even bullying in the public school system, the practitioner is operating directly within the conflict, even if the practitioner is not a stakeholder. Mental health practitioners typically do not operate in such a fashion. It is very important for conflict resolution practitioners to build good support systems and seek respite to avoid burnout so that they may continue to do their important work.

A CALL TO ACTION

Unfortunately, little research has been pursued regarding the effects a large-scale mental health epidemic may have on a global level. However, as mentioned earlier, today we are seeing the makings of one in the Syrian refugee crisis. Though I am hopeful that the world will continue to transform and expand viewpoints and understanding of the refugee experience, and will find reason and purpose in offering greater refuge, the current situation – as of September 2015 – seems to be one of apprehension. Everyday more

people cross borders in hopes of finding asylum and the political atmosphere is thick with divisions.

Though the world continues to discuss, the crisis continues, moving forward into whatever it will become. Poor mental health has been recognized as one of the primary health concerns in the current refugee crisis; the severity of mental health compromise in the Syrian crisis is especially worrisome. As discussed in the previous three sections, there are very real impacts that may occur secondary to unmitigated mental health crisis. What this brief section is meant to convey is the fact that these impacts are not bound by borders, nor are they tethered to ethnicity, religion, or culture. The lives of these people are joined with the global populace and what happens to them happens to all; it is our *response* that will dictate what is to come. Their suffering is our suffering, and just the same, their resiliency is our resiliency. If we choose to approach this issue from a multidisciplinary lens, we arm ourselves with greater knowledge and more diverse tools to respond in a manner that promotes peace and long-term stability.

I hope that this capstone may serve to not only educate those who are interested in such a topic, but may prompt practitioners of all disciplines to answer to this global need. Though I make a point to speak specifically about mental health, this call to action is meant to encompass all disciplines and aspects of practice. This is not just a refugee crisis; it is a humanitarian one in every sense of the word. We must respond with empathy and be mindful of our privilege and power, recognize that conflict and crises are perpetuating occurrences and if we do not pursue deeper resolution and sustainability, if we do not see our own well being reflected in others and wish for them to thrive, we will continue to see suffering.

A NOTE ON EMPATHY

Of all the points that have been made, I wish to reiterate one in particular. We must not only increase our knowledge and supplement our practice. We must develop and practice deeper empathy, to want the same contentment and freedom from psychological burden for others as we do for ourselves. This may be idealistic, but it is not completely unreasonable; practicing such empathy may allow us to better understand the futility and pain of such conflicts, and ultimately, may urge us to put an end to them. Catering to a better global health is, in effect, working towards a world that devalues suffering and elevates peace.

CONCLUSION

The connection between mental health illness and ongoing conflict is a strong one. With the slow de-stigmatization of mental health occurring today in the west, and greater awareness and understanding of conflict populations – today's refugee crisis is certainly providing a global educational opportunity – there has never been a better time to find the intersection between the two in practice. Conflict transformation practitioners, human rights advocates and mental health practitioners can work together in order to address the burden of PTSD and other mental health issues in order to serve the goals and needs of those they serve, and to further developmental efforts in a manner that promotes wellness and is more sustainable.

Mental heath must be more greatly understood as a real and pervasive effect of conflict – too often is it forgotten and too long do those enduring psychological trauma go untreated. As explored in this capstone, it has definite impacts on both the individual

and community levels and can, unmitigated, affect social structures as well as economic ones. My own work and research pursuits lead me to believe deeply in the importance of sustained mental health intervention in refugee populations, and more generally speaking, in those coming from a background of conflict or trauma. As we look forward and wait for the slow unraveling of this crisis, and in anticipation of receiving refugees, mental health intervention and social services must be made available in order to ensure greater individual and community health.

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