Wars, genocide and health

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WARS AND GENOCIDE

The World Health Organization defines violence as the mayor threat to public health and divides violence into three broad categories according to characteristics of those committing the violent act: self-directed violence, interpersonal violence and collective violence.[1] Collective violence is subdivided into social, political and economic violence. Political violence in this definition of the WHO includes war and violent conflicts, including, among others, state violence and terrorist acts. In this definition genocide is not included in political violence, but it should be as it was one of the major threats to health in 2011.

Genocide means »*any of the following acts committed with intent to destroy, in whole or in part, a national, ethical, racial or religious group as such: killing members of the group, causing serious bodily or mental harm to members of the group, deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part, imposing measures intended to prevent births within the group, forcible transferring children of the group to another group*« (Convention on the Prevention and Punishment of the Crime of Genocide«, United Nations, 1948). More people were killed because of genocide in the 20th century than through any other cause (approximately N=174 million).

Since the second half of the 20th century, political violence has changed its face from mostly inter-state to intra-state conflicts, which has resulted in increased vulnerabilities of civilian populations affected by political violence.[2] Knowledge related to the health and long term effects on populations affected by political violence is sorely needed to develop tailored rehabilitation measures for those affected populations.

WARS, GENOCIDE AND MENTAL, PHYSICAL AND SOCIAL HEALTH

Political violence may have an impact on mental health (e.g. common mental disorders, post-traumatic stress disorder, sleep disorders), on physical health (e.g. mortality, cardiovascular health) and on social health (e.g. on domestic violence).

Wars, genocide and mental health

Worldwide, studies have been conducted on the impact of wars and genocide on mental health. These studies suggest an impact of wars and genocide on the prevalence and extent of mental disorders and distress in childhood and in adult life.[3-9] Since the early 1980s, there has been a remarkable increase in research on the mental health and psychopathology of people affected by war and genocide. Previously, at least four systematic reviews [10–13] and at least four narrative reviews [14–17] have investigated the impact of wars on mental health, e.g. Lindert et al. analysed 36 surveys comparing the prevalence of depression and PTSD among refugees, asylum-seekers and labour migrants and found that rates differed substantially[18] with highly increased rates among people affected by wars. These reviews show clearly that refugees and asylum-seekers who reported exposure to political violence were more likely to meet criteria for psychopathology (e.g. depression, anxiety, PTSD) in almost every study that has been done. Violence of all kinds has been shown to be associated with an increase in psychopathology in all countries where studies have been undertaken.[19]

The long-term impact of DV and PV may comprise a variety of psychopathological reactions such as common mental disorders (CMD), posttraumatic stress disorder, sleep disturbances, suicidal behavior and (subsyndromal) mental distress. Regarding anxiety disorders, Sharon et al (2009) found a 22 fold increase in the prevalence of anxiety disorders among elderly genocide survivors compared to people in the comparison group, adjusting for socio-demographic characteristics and exposure to recent traumatic events. CMD might be related to *sleep disorders*. The percentage of genocide survivors who reported at least one sleep disturbance was twice as high as that for individuals of the comparison group after adjustment for potential confounders in the community study cited earlier.[20]

Studies on war and *posttraumatic stress disorders* (PTSD) are not consistent. Post-traumatic stress disorder is a serious and complex disorder with emotional, cognitive and physical symptoms. PTSD can be diagnosed according to six criteria. Criterion A of the Diagnostic and Statistical Manual of Mental Disorders IV (Text Revision)[21] specifies that, for it to be diagnosed, a person must have »experienced, witnessed, or been confronted with an event that involves actual or threatened death or injury, or a threat to the physical integrity of self or others« (criterion A1) and the person must have a subjective emotional response that in-

volved »intense fear, helplessness, or horror« (criterion A2). PTSD is by far the most common mental health problem diagnosed among refugees and asylum-seekers, as has been documented in numerous studies of populations affected by political violence[22]. There is consensus that certain PTSD symptoms (nightmares, flashbacks, intrusive images, heightened startle response, sleep disturbances) are found in people who survived political violence from diverse cultural contexts.[23–27] In almost all studies on war and genocide, the number and severity of symptoms reflected the level of violence suffered by these persons.[30]

War, genocide and physical health

Studies suggesting an impact of genocide in war on physical health years after the war and/or the genocide ended are not conclusive, with studies suggesting an association of exposure to war and genocide with increased mortality late in life[31] and others suggesting no differences in late life-mortality for people exposed to wars and genocide, compared to those unexposed.[32]

Studies of exposure to war suggest physiological changes associated with violence with increase of basal cardiovascular levels, decrease of heart rate variability (HRV) and dysregulation of cortisol levels.[33, 34, 35] In a study on the association between exposure to DV and blood pressure women who were 6-8 years old and men who were 9-15 years old at the time of exposure had higher systolic blood pressure compared to unexposed subjects born during the same period of birth (fully adjusted difference 8.8, 95% CI: 0.1–17.5 mm Hg in women and 2.9, 95% CI: 0.7–5.0 mm Hg in men). Higher mortality from ischemic heart disease and cerebrovascular disease was noted in men exposed at age 6–8 and 9–15, respectively. It might be that impact of DV and PV changes over the life course according to age and resilience and recovery factors.

War, genocide and social health

However, political violence is not only related to psychopathology and physical health seekers at the individual level, but also affects social health, with repercussions for families, communities and social institutions. At the family level, the adverse impact of political violence on the structure and function of nuclear and extended families has been well documented, for example with regard to heightened family violence. At a community level, networks of social relations may be shattered, creating profound distrust, animosity and wariness towards social institutions among those affected by political violence. In addition, survivors of political violence have been found to adopt violent solutions to conflict within partnerships[36], the community[37], and society at large.[38, 39] In a study on adult attachment de Haene et al. (de Haene, 2010) provide an overview of the relationship between parents and children of refugee families, as political violence may increase violence within the family and between family members. Further study is required on the impact of political violence on the scope and extent of domestic violence.

War, genocide and resilience and recovery

Resilience and recovery are distinct outcome trajectories that are empirically separable following highly aversive events.[40, 41] *Resilience* is described as the ability to retain a level of physical or emotional health after a traumatic event e.g. despite experiencing adversity.[42] However, up until now, no consensus on an operational definition of resilience exists. The first differences in definitions centre on conceptualising resilience as a personal trait, compared with a dynamic process. Pioneering research on resilience focused on childhood adversities and negative life events such as deficient parenting, poverty, homelessness, traumatic events, natural disasters, violence, war, physical illness and resilience as a personal trait. Subsequent research focused on the contribution of systems (families, services, groups, and communities) in assisting people in coping with adversity. Accordingly, the definition of resilience extended to include protective and vulnerability forces at multiple levels of influence – culture, community, family and the individual. Further research suggests that resilience is not static; it may vary over time and across developmental phases – a person's resilience status can change from resilience to non-resilience and vice versa.[43] Resilience in the context of wars and genocide needs to be studied. *Recovery* describes the ability to regain health after experiences of potentially traumatic events. It might be that DV and PV have an unknown long-term impact on health which might be moderated by resilience and recovery factors. Surprisingly few empirical studies have been conducted on war, genocide and mechanism of recovery.

CONCLUSION

Political violence apparently has a significant short and medium impact on mental, physical and social health but further knowledge is needed to understand better the impact of political violence and resilience and recovery as regards mental, physical and social health.

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Abstract

KRIEG, GENOZID UND GESUNDHEIT

Gewalt stellt, insbesondere wenn diese kollektive Ausmaße annimmt, eine der größten Herausforderungen für den Bereich Public Health dar. Krieg und Genozid wirken sich auf die physische, psychische wie auch die soziale Gesundheit der betroffenen Gesellschaft sowohl kurzfristig als auch auf lange Sicht aus. Ein vertieftes Wissen bezüglich der Präventionsmöglichkeiten sowie der Optionen zur Unterstützung von Resilienz- und Recoveryfaktoren sind für die Entwicklung gezielter Interventionen unerlässlich.

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