What is mental health and how is it harmed by conflict and violence?

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Abstract

One of the consequences of all the Organised Violence and Torture (OVT) that has afflicted Zimbabwe for the past 40 or so years is a very large number of person suffering from trauma-related disorders. Studies of the prevalence of psychological disorders generally show that the overall prevalence rose by nearly 11% between the late 1980s and 2005. However, the prevalence amongst persons exposed to OVT is considerably higher, with estimates ranging from 13% to over 70% depending on the group studied. This report provides a brief overview of OVT and its consequences, pointing out the likely psychological effects and the need for a comprehensive mental service addressing the needs of all sufferers.

Introduction[1]

Zimbabwe, despite its deceptive appearance to the naïve outsider, is a country beset by Organised Violence and Torture (OVT) for many decades. It was brought into being by a colonial war, suffered violence and displacement through the 70 years of settler domination, liberated through a civil war, suffered through low intensity conflicts in the 80s, and a long, sustained period of episodic violence has characterised the country since 1999 to date. It is therefore hardly surprising that this has resulted in great and continuing suffering for a very large proportion of its people.

It is interesting that the new country of Zimbabwe came into being just as mental health professionals were beginning to realise the pernicious consequences of OVT. The first official classification of psychological disorders due to trauma, Post-Traumatic Stress Disorder (PTSD) came in 1980. A decade later, in Southern Africa, the impetus for dealing with these problems came in 1990 in an important conference held in Harare.[2] This conference led to a sudden growth of organisations across Africa, paralleling similar growth around the world, with local organisation, the Amani Trust, being amongst the first of these, together with what became the Centre for the Study of Violence and Reconciliation (CSVR) in Johannesburg and the Trauma Centre for Survivors of Violence and Torture in Cape Town. There are now 150 such centres in 75 countries across the world, attesting to the importance that health professionals now accord the health consequences of organised violence and torture.

Conflict and Violence in Zimbabwe

Although, as pointed out above, OVT had been a feature in Southern Rhodesia's history since the beginning, the very serious escalation came in 1965 with UDI. I will thus confine myself to events from this point onwards, but civil society has previously recognised that this is arbitrary, and any true understanding of OVT will have to go back to the end of the nineteenth century.[3]

This history has been given in some detail elsewhere (CSVR. 2009), and I will not go into any here, but rather quickly describe the main periods and events:

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[1] This report was written by Tony Reeler, Consultant Senior Researcher (RAU).

[2] Psychiatric Association of Zimbabwe (1990), Report on an International Conference on "*The Consequences of Organised Violence in Southern Africa*", Harare: PAZ.

[3] See the Symposium Declaration in *Themba Lesizwe (2004), Civil Society and Justice in Zimbabwe, Proceedings of a symposium held in Johannesburg, 11-13 August 2003, Pretoria: Themba LeSizwe*.

- The Liberation War (Most seriously from 1972 to 1979);
- Gukurahundi (1982 to 1987);
- The violence on the Eastern borders due to the Mozambican civil war (1980 to 1992);
- The Food Riots (1999);
- Elections (2000, 2002, 2005 & 2008);
- The "Farm Invasions" (2000 to 2003);
- Operation Murambatsvina (2005);
- Post-coup violence (2018 to date).

This is of course not inclusive, but indicates there has been significant violence for nearly 50 years, with only the period from 1987 to 1999 being relatively peaceful, apart from continuous incidents along the Mozambican border.

All Zimbabweans understand this history, but some will bitterly dispute the political interpretations that have accompanied the documentation of the events. However, from the perspective of the victims and survivors, it is indisputable that there has been considerable OVT over the past five decades, and empirical evidence demonstrates that Zimbabwe, of all SADC countries, has been the most violent since all these countries attained full independence (RAU. 2016 (a)). There is also evidence that OVT has worsened since the coup in 2017 (ZHRNGOF. 2019).

However, this is not the place to discuss the political implications of this history, but to examine what are the consequences for the victims and survivors.

The prevalence of trauma related disorders

It is important at the outset to reflect on the deep knowledge gained across the world about the health consequences of OVT, and to highlight a number of crucial learnings. The first is that the most persistent consequences are psychological in nature. Physical abuse is the commonest association that we make with OVT, with torture, assault and rape being the most visible. This is not to minimise deaths due to OVT, or their effects on families and communities, but, as we shall see, surviving victims due to physical abuse greatly outnumber those that died.

The second difference is between direct and indirect victims. It cannot be assumed that this implies lesser consequences of the latter. A very comprehensive analysis of the effects of OVT concluded that the difference between those that were tortured and those that lived in a state of "terror" was only in the kinds of disorders found (Steele et al. 2009). Reporting on 181 studies with an overall sample of 81,866 victims and survivors from 40 countries, Steele and colleagues conclude that PTSD is associated strongly with torture (direct victims) and Depression associated with political terror (indirect victims).

Political terror usually affects civilian populations. It also is referred to as "high war zone stress" to describe situations where military personnel are surrounded by battles and killings, but may not be direct combatants. For example, there is a difference between a soldier that is repairing vehicles on the front line and soldiers actually involved in fighting. Political terror, as distinct from direct experience of OVT, could be described in Zimbabwe for those persons forced to live in "keeps" during the Liberation War, and also for those living in rural communities at other times, such as during Gukurahundi, or during the more violent elections since 2000.

The third is about the "dose-response" effect. Contrary to some common beliefs, exposure to abuse does not lead to victims becoming immune or adapted to this, rather the more often abuse occurs the worse its effects.

Finally, there is the matter of "chronicity". Early treatment generally is associated with a better prognosis, and this is true of psychological disorders, as well as disorders due to trauma and OVT. I will deal with this is more detail later, but it is sufficient here to point out that many victims in Zimbabwe have been unable to access appropriate treatment. Some is the result of lacking knowledge of the symptoms and others due to lack of proper and accessible health care in the vicinity. In other cases it is either because (medical care) none existed (as was the case for many victims from the Liberation War), or have been denied treatment, as has been the case for many in the contemporary period from 2000.

Table 1: Zimbabwean studies on the prevalence of Common Mental Disorders (CMD) and Trauma

Source: Parsons et al.2009

Study	Sample	% prevalence
Community mental health:		
Williams & Hall [1987][i]	District Hospitals	11%-37%
Reeler, Williams & Todd [1991][ii]	Primary care clinics	24%-28%
Community survey [2006. unpublished][iii]	Primary care clinics	39%
Trauma samples:		
Amani Trust [1996][iv]	War veterans	73%
Amani Trust [1997][v]	Community survivors of Liberation War	13%
Amani Trust [1998][vi]	Gukurahundi survivors	50%
,Human Rights Forum [1998][vii]	Food riots victims	36%
Amani Trust [2002][viii]	Commercial farm workers	81%
Action Aid International [2005][ix]	Victims of Operation Murambatsvina	69%
Idasa [2006][x]	Zimbabwe refugees in South Africa [street survey]	47%
ZTVP [2007][xi]	Women refugees in South Africa [clinic attendees]	71%
SACST [2008][xii]	Zimbabwe refugees in South Africa [multiple sites]	50%
WOZA women [2007][xiii]	WOZA members	53%

As is evident from the table above, the prevalence rates vary quite considerably, and this requires some brief explanation. The studies, under the heading ***community mental health***, deal with studies of patients attending primary care facilities, screening for what are termed "Common Mental Disorders" (CMD), and are not screening explicitly for disorders due to trauma. However, the third study, the community survey, did examine precipitating factors, and, amongst these, *experience of violence* and *property destruction*, were strongly associated with psychological disorder. This study was carried out in Harare, and after Operation Murambatsvina (OM) in 2005. The ActionAid study in 2005, some months after OM, had a considerably higher prevalence rate (69%), reflecting an acute response to the displacements, and the later study reflected a lower prevalence. However, it should be noted that the

prevalence rate in Harare in 2006 (39%) was conservatively 11% higher, reflecting both violence and displacements.

The other studies are all of groups that were victims and survivors of OVT, and are obviously a select population: rates of psychological disorder should be high in these groups. Two studies examined the prevalence of victims and survivors from the Liberation War, and these were persons examined more than decade after their experience of OVT. Similarly, the Gukurahundi sample also was seen 10 years after the OVT experience. The remaining groups were all victims and survivors of events after 2000, and included refugees, who probably had additional trauma from the displacement experience. There are also two studies that looked specifically at women (CSVR. 2006; WOZA. 2008). As can be seen, the prevalence rates vary considerably, and clearly point to the need for a large-scale epidemiological study in order to get a good, national understanding of the scale of the problem.

It is not the place to try to unpack the reasons behind the variance in all these groups as the measure is deliberately crude, merely methods of distinguishing gross rates of disorder, essentially separating sheep from goats. However, the point here is that we should expect there to be many victims and survivors of OVT in the general population of Zimbabwe, and stemming from all the violence over the past five decades.

The most important question, though, is what happens to the victims and survivors? What might be their lived experience in the aftermath of living through a period in which OVT or political terror was common? The international literature is replete with information.

The health consequences of OVT

Before detailing these, it may be useful be a little more specific about OVT. Ordinarily, OVT is in the minimalist term, war: this war can be against another country, part of a country (civil war), or a group of people who would have taken up arms against a constitutionally organised government (rebellion). However, OVT is not just a function of a war situation: it can go beyond it and be deployed as a means of quietening dissent and opposition.

Types of OVT

It should be borne in mind that the consequences of OVT are multiple. There are obviously the effects on the victim, but not merely on the victim, as the experience of OVT often is witnessed by families and others, by adults and children, and may even have effects on communities. This last effect is covered by the term "political terror", and, as pointed out earlier, there are differential health consequences for political terror (depression) and OVT (PTSD). It is thus worth pointing out very briefly the kinds of events that are likely to have health consequences:

- Physical abuse (beatings, rape, suspension, burnings, etc.);
- Deprivation (food, water, sleep, isolation, etc.);
- Sensory overstimulation (drugs, powerful lights, constant noises, etc.);
- Psychological abuse (threats, threats against family, sexual abuse, simulated execution, etc.);
- Witnessing (beatings, rape, executions, etc.)[4]
- Disappearances;
- Forced displacement.

These can occur singly or in combination, but it is extremely rare that any form of physical abuse or sensory overstimulation can occur with some form of accompanying psychological abuse.

As pointed out earlier, there can be both direct and indirect victims and survivors. For example, a man can be beaten in front of his family, or even in front of a whole community, and he may experience both physical and psychological abuse, but the family members or the community, through witnessing the abuse, may be subjected indirectly to psychological abuse. People outside this event, especially if such events are common in the geographical area, who hear about these frightening events, or meet the victims, or know the victims, are probable casualties of political terror. Here it is important to stress the impact of witnessing on children, and especially young children, and it is common for children to have witnessed OVT (PTUZ. 2012; Reeler. 2013).

Disappearances are a particularly destructive abuse, leaving families in endless grief, communities in a state of political terror, and hence regarded as a very severe human rights abuse. Zimbabwe has many examples of disappearances; from the Liberation War, Gukurahundi, and to a lesser extent since 2000, but there have been isolated cases throughout the period since 1980.

Rape, of course, is an extremely serious form of abuse, both for women and men, with not only the psychological consequences but also the high risks of HIV infection (RAU. It often is much worse by the reluctance of victims to seek either legal or medical assistance (or both), due to shame or fear (RAU.2010).

Finally, forced displacements are another serious abuse, leaving families and communities vulnerable and at risk of multiple health problems. Forced displacements can be internal, as in the forcing people into "keeps" during the Liberation War, during the "farm invasions, and during Operation Murambatsvina (RAU. 2016 (b)). They can also lead to external displacement, with people becoming refugees, and this has been a continuous feature over the past 40 years.

Health consequences

Health consequences are physical, psychological and social.

Obviously, there can be very serious physical consequences from all types of physical abuse, and here early treatment is critical for avoiding long-term physical disability. Unfortunately, many victims do not get early treatment, and studies of the victims of the Liberation War demonstrated a high percentage of persons living with disabilities that, with proper medical care, might have been avoided (Amani. 1998). It is often the case, however, that threats to bodily integrity get greater priority than psychological or social consequences. This is not to undermine the importance of appropriate and early intervention, or rehabilitation, but merely to point out that care of those suffering from the effects of OVT require a holistic approach, and this is well recognised internationally (Mollica et al. 2004; WHO. 2003).

It is not only early treatment that is important in dealing with the sufferers of physical abuse, but it is important also for appropriate rehabilitation, even for those for whom the abuse occurred many years ago (Amani. 1997). Many people are unwilling to seek early treatment for a variety of reasons, fear predominantly, and hence any programme of assistance must bear in mind the issues around "chronicity".

The same points can be made about those suffering primarily from the psychological consequences. It is important to stress here that PTSD is not the only consequence of OVT,

and the victims can suffer from a range of different disorders, and sometimes even in concert (co-morbidity). Studies of the war victims of the Liberation War, particularly war veterans, indicate a variety of different conditions (Reeler & Mupinda. 1996). Whilst PTSD was common, 28% had PTSD, so were Common Mental Disorders (CMD) and Somatoform Disorders[5] (Table 2 over).

Table 2: Diagnoses given to war veterans

Common Mental Disorder	33%
PTSD	28%
Somatoform Disorder	24%
Depression	12%
Anxiety	4%

The social consequences are equally important. Becoming a victim of OVT profoundly affects the person's worldview, what some have termed creating an "existential crisis" (Turner & Gorst-Unsworth. 1990). All citizens, old and young, are socialised into trusting the outside world – schools, policemen, governments, etc. – and when this trust is shattered by OVT, especially when committed by state agents, then the victim has a very serious crisis of trust. It is even worse when communities become involved, with both perpetrators and victims within the same community. Thus, re-building trust through peace building, re-integrating communities, and transitional justice becomes an imperative and is an actual health issue. The crisis is further made worse when the participants in the OVT include close community members. The whole building blocks of community cohesion based on trust can be destroyed and the challenges the existential elements in humans as they see everyone as an enemy. Here it is worth commenting that political trust in the state and government is a very scarce commodity since 1999 at least (RAU. 2019).

Chronicity

Chronicity needs some brief discussion. Zimbabwe, as we have seen, has a long history of OVT, and a very poor history of addressing the health consequences. In the past this has been the consequence of a lack of awareness on the part of health professionals, and more recently has been the consequence of denial: OVT is different from many other kinds of trauma because it *prima facie* deals with gross human rights abuses, clearly something that few governments wish to confront. The effect is that Zimbabwe has very large numbers of victims and survivors for whom there has not been adequate care or even care at all.

This describes a situation in which disorders can be chronic, and this has important implications for any national system to address the consequences of four decades of OVT. By way of illustration, a small (unpublished) study compared victims of the Liberation War (n=402) with more contemporary victims (n=586), was seen between 2000 and 2002 (Reeler. 2005). There were a large range of interesting findings, but here we will focus on the issue of chronicity, bearing in mind that the comparison involves not only the difference between the experiences of OVT and when the person received help, but also between civil war and election violence.

The 1970s group was obviously older and there was obviously a much longer time between experiencing OVT and finally getting assistance. It also reported similar rates of physical torture, sensory over stimulation, deprivation, and witnessing assaults, whilst the 2000s group

[5] Somatoform Disorders describes conditions in which the sufferer focuses wholly on physical symptoms. There may well be another comorbid condition such as PTSD, Depression or Anxiety, but the person "insists" on the focus being placed on the obvious physical symptoms.

reported higher frequencies of psychological abuse, and surprisingly a slightly higher rate of witnessing executions.

Table 3: Comparison of victims from 2000/2002 with victims from 1970s [6]

	2000	**1970**
Gender (Male)	76.5%	63.3%
Age	33.3	52.2
Adult Witness	28.8%	51.8%
Child witness	22.9%	51.8%
Physical abuse	80.9%	79.8%
Deprivation	11.6%	52.8%
Sensory-overstimulation	4.7%	26.0%
Psychological abuse	87.5%	70.4%
Witness assaults	64.9%	78.3%
Witness executions	4.1%	1.5%
Present State of Health Questionnaire (PHSQ)	6.6	6.5
Self-Reporting Questionnaire (SRQ-8)	1.9	2.9

There was little difference between the two groups in the number of health problems reported on the Present Health Status Questionnaire (PHSQ), but the measure for psychological disorder, the Self-Reporting Questionnaire (SRQ-8) was significantly higher in the 1970s group, which suggests that chronicity may be operating here. However, it must be pointed out that there is a possible interaction between chronicity (time between the OVT and treatment) and the severity of the OVT. Here some workers have suggested that it is not the severity *per se* of the trauma that matters, but more the subjective view of that severity (Basoglu & Paker. 1995; Feinstein & Dolan. 1991). This supports the notion that OVT, in addition to the many health consequences, also results in an "existential crisis" (Turner & Gorst-Unsworth. 1990).

There is much more that can be said from this study, but here it is sufficient to point out that time does not heal. Furthermore, the 2000/2002 group was a very small sample of the very large number of victims from that period, many of whom probably did not get adequate assistance, and this group has been added to considerably since then, especially from the violence in 2008.

Conclusions

This very brief review cannot possibly do justice to either the lengthy history of OVT in Zimbabwe, nor cover all the issues that emerge out of the research to date. Hopefully it does give a good flavour about what are the mental health needs that the country must address and the extent of the problem that a mental health service (and the health service) must deal with. It is clearly not a small problem, but must deal with the physical, psychological and social needs for a very large number of our citizenry.

As was evident from this brief description of the problem, we are adding to the morbidity year by year, and decade by decade, and hence the scale of the rehabilitation needs are growing. An obvious pre-requisite is to stop adding new cases, and this means a determined effort at peace building, but also the commitment to develop non-violent methods of conflict

[6] All these differences were statistically significant ($p=0.000$).

resolution. Prevention is always better than cure, but the evidence does not suggest that the country has managed this at all well.

It is critical that we get a good overview of the scale of the problem. The observations here are based on small studies only, and mostly from non-governmental organisations. The time is long past for a large epidemiological study of the prevalence of disorders due to OVT for this will be fundamental to planning an appropriate health care system with a mental health care system inclusive all who suffer from mental disorders, whether produced by OVT or any cause. All of this is given even greater urgency with the newest crisis facing Zimbabwe, Covid-19, which adds further stress on an already traumatised nation, and importantly on the front-line health care workers (Lai, Simeng, Ying et al. 2020)

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