Mental health under war conditions during the 1991-1995 war in the former Yugoslavia

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Identifying needs and resources

It has been said that the first victim of war is the truth. The health variation of this saying has the practical consequence that medical data are turned into military secrets (death tolls, the number of wounded, etc.). Combined with the fact that the normal, peacetime, health information systems break down, humanitarian assistance programmes are forced to plan on the basis of a very uncertain war epidemiology. One must rely on direct field observations, if access is not hindered by heavy warfare, compiling and analysing scarce data from the past and present, fitting them into a pragmatic mosaic, and making qualified estimates and calculations from existing professional knowledge. The mental health field is no exception. The nature of mental health problems does not especially facilitate this work either.

More than 1 million people are in need of help, but who will help them?

An estimate by the WHO mental health unit based in Zagreb calculated the number of people in need of assistance from the perspective of war as a “peacetime disaster”. The estimate indicated that the core group in severe need of help may be about 1 million people (or 5% of the original population in the former Yugoslavia). It was also estimated that about 5,000 full-time professionals, experienced in trauma work, would be needed to cover the emergency needs, while the actual number of skilled professionals in the field amounts to about 200. The consequent imbalance between the needs and the helping capacity bring us to the first conclusions:

(i) There is an imbalance between the frequency of mental health problems (e.g., war-traumatized people) and the helping capacity of the local professionals;

(ii) It is not possible to solve even the emergency problems through traditional treatment procedures of therapeutic interventions. Self-empowerment and capacity-building in the population and among professionals on all levels are essential elements.

(iii) In the war-affected countries a high percentage of the population might suffer a “collective trauma”. They will probably experience a significant reduction in their quality of life due to mental health problems related to unmet therapeutic needs. The consequences are expected to be a significant threat to the public mental health of these countries. We can expect changes such as: increased frequency of alcohol and drug abuse (e.g., self-medication); increased suicide and homicide rates; increased frequency of criminal and structural violence; and of trauma-induced psychotic manifestations; and, in general, transitional problems turning into chronic mental illness.

War traumas: concepts and understanding

Psychological war trauma concerns injury or damage to different aspects of intrapsychic and psychosocial functioning. The trauma (e.g., “wound”) is caused by the experience of traumatic events. The degree of traumatization varies with the balance between the strength of the stress factors, and individual protective factors and is reflected in the symptomatic traumatic reactions (often categorized as traumatic stress disorders) and the complications thereof (1).

Stressor factors (stressors) in the most critical traumatic events contain elements of threat, injury, exposure to death, destruction and human suffering (2).

Target object may be a person, a family, a group or even the whole society. Examples of vulnerable groups under war conditions are children and adolescents, the elderly, the refugees and internally displaced people (Fig. 1), and the families of the “disappeared” and killed. In the post-war phase, the home-coming soldiers, who have to change back from warriors to their old roles as fathers, spouses, sons, brothers and lovers, present a new challenge. This group may be traumatized by having witnessed or committed war atrocities.

Traumatic reactions are symptoms of traumatic stress and may lead to serious mental health complications as mentioned above. The experience of a traumatic event may cause post-traumatic stress disorder (PTSD) in some, while others may not develop the symptoms. The symptomatology of traumatic stress disorders, however, is quite similar on the individual level regardless of the kind of traumatic event. The most common features are:

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Wid hffh statist. quart., 49 (1996)
Refugees and displaced patients among 1,801 patients in 9 psychiatric institutions in Bosnia and Herzegovina (BIH), Croatia and the Former Yugoslav Republic of Macedonia (FYROM), 18 October 1994

Réfugiés et personnes deplacées parmi 1,801 malades de 9 institutions psychiatriques en Bosnie-Herzégovine, en Croatie et dans l'ex-République yougoslave de Macédoine, 18 octobre 1994

Non-residents by country – Non-résidents par pays

(i) intrusive phenomena related to the traumatic event (nightmares, flashbacks and intrusive thoughts – most often accompanied by anxiety); (ii) various forms of avoidance, detachment, memory loss and psychic numbing; and (iii) provocation of the symptoms when exposed to trauma-like or trauma-symbolic situations.

Under war conditions, traumatic events involve frequent, repetitive impact of stress factors which are experienced by the victims in a context of threat, and of systematic and deliberate violation of fundamental human rights. The symptomatology of war trauma, therefore is more complex than the symptomatology seen in “single event traumas” in peacetime.

Psychosocial and mental health interventions under war conditions

The massive media interest in reports of mass rape in 1992 provoked the international community to respond. Funds were made available for the support of rape victims. Due to the problems of identifying a sufficient number of raped women, most of the projects, in practice, turned into broad-spectrum psychosocial assistance to women and children.

This is the first war where large scale psychosocial/mental health interventions took place as part of an emergency programme. In January 1995, Agger et al. (3) reported and analysed the content of nearly 200 psychosocial projects which were in progress in Bosnia and Herzegovina and Croatia. This overview has created a comprehensive understanding of such interventions in future conflicts. In a recent evaluation study of the outcome (4), the efficacy of the psychosocial projects was strongly substantiated.

The WHO Regional Model on Mental Health

In 1994, the newly created WHO mental health unit, located in Sarajevo, developed the WHO Regional Model on Mental Health based on field observations and an intensive dialogue with local mental health professionals (5). On 10 October 1994, World Mental Health Day, the first regional model was inaugurated in Sarajevo. Since then, 6 additional regional models have been implemented in Bosnia and Herzegovina (Mostar, Tuzla, Bihac, Zenica/Travnik), Croatia (Split) and Montenegro (Kotor). A further 4 or 5 models are planned, to be implemented during the post-war phase, in 1996.

What is the WHO Regional Model on Mental Health?

The WHO Regional Model on Mental Health is a coordinated set of mental health activities for a defined geographic area with a population of
300 000 - 400 000 inhabitants, including 4 essential elements.

**WHO-chaired regular coordination meetings on psychosocial/mental health**
Participants are representatives from the inter-governmental organizations, the non-governmental organizations (NGOs) and national health organizations working in the psychosocial/mental health field within the region.

**A WHO regional coordination centre**
The WHO coordination centre's main activity is the assessment of the psycho-social /mental health needs and resources in the region through systematic field observations, updated overviews and monitoring of the situation. Focus is both on the war-traumatized population and the traditional target group of patients with mental illness and learning disabilities (*Table 1, Fig. 2)*.

**Self-empowerment and capacity-building among professionals at all levels**
Systematic training of local professionals was established in different types of courses. Some targeted therapists (post-traumatic therapy, or PTT, courses), other counsellors, school teachers and primary health care professionals. All courses have elements of theoretical and practical training, case supervision and self care (i.e., "taking care of the caretakers"). As of June 1996 more than 200 psychologists/psychiatrists had participated in the one-year postgraduate PTT-programmes.

**Promoting a community-oriented mental health approach**
The pre-war mental health system focused on a traditional, institutionalized approach. Due to the destruction of mental health facilities, the unequal distribution of mental health institutions caused by the new borders, and the "brain drain" of local professionals, favoured a shift towards the community-oriented approach. The war context offered an opportunity for change that was pro-actively supported by WHO. These key activities were further supported through distribution of medical supplies (in 1995 WHO distributed 373 mental hospital kits in the region), exchange visits, seminars and special mental health/ human rights activities.

**Mental health and human rights**
The substantial increase in mental health problems is basically due to war-related traumatic reactions and the consequences hereof. These are primarily caused by violations of basic human rights. Widespread trauma must be seen as the reaction of normal people to a sick situation. The international community was able to offer protection for projects which addressed special mental health issues related to

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*The data in Table 1 and Figs. 1 & 2 are based on a survey of all in-patients carried out in 14 institutions in Bosnia and Herzegovina, Croatia and the Former Yugoslav Republic of Macedonia on 18 October 1994.*

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**Table 1**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Bosnia-Herzegovina</th>
<th>Croatia</th>
<th>Former Yugoslav Republic of Macedonia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>47%</td>
<td>36%</td>
<td>46%</td>
</tr>
<tr>
<td>Depression</td>
<td>3%</td>
<td>13%</td>
<td>7%</td>
</tr>
<tr>
<td>Dementia</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other psychotics</td>
<td>9%</td>
<td>20%</td>
<td>11%</td>
</tr>
<tr>
<td>Borderline</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Psychopathy</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Neurosis</td>
<td>17%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Other non-psychotic disorders</td>
<td>5%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>14%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>2%</td>
<td>14%</td>
<td>23%</td>
</tr>
<tr>
<td>Mentally retarded</td>
<td>2%</td>
<td>6%</td>
<td>10%</td>
</tr>
</tbody>
</table>

*Source: Data from the WHO Mental Health Unit, Zagreb, The 18 October Survey. – Données de l’unité de Santé mentale de l’OMS, Zagreb : enquête du 18 octobre 1994.*
human rights violations. Examples are the problems of families of the "disappeared" and killed (6), the sexually violated (7) and mixed marriages (8).

**How should the aid provided in an international mental health emergency end?**

Since this is the first war where large scale psychosocial/mental health assistance was introduced as part of an international emergency response, we may conclude by asking the question, "How should such an intervention end?" The essential problem is that the mental health consequences of war trauma are expected to continue for many years after the war. There is a need for continued and sustainable activities to prevent a health disaster rooted in the complications of war trauma.

The European University Centre for Mental Health and Human Rights (EUC-MHR) (9) is proposed as a new structure to document the past ("What did really happen during the war?") and to monitor the future mental health consequences with the aim of developing comprehensive preventive strategies. Besides documentation, EUC-MHR can continue undergraduate and postgraduate training and can explore the transferability of the lessons learned from the 1991-1995 war in the former Yugoslavia as a form of disaster-preparedness for future conflicts.

**Summary**

If this war were a "peace time disaster" it is estimated that more than one million people would be in need of assistance due to mental health issues. The estimated helping capacity, however, can cover only a small proportion of the need. This imbalance may create a severe threat to the mental health of the war-torn population in a medium- and long-term perspective. Complications related to war-trauma-induced stress disorders may give rise to significant increases in alcohol and drug abuse, domestic and criminal violence, suicides, homicides and chronic mental illness.

This article outlines the international efforts to include psychosocial and mental health interventions as part of the emergency assistance programme. Special emphasis is directed at the development of the new WHO Regional Model on Mental Health. The model is a coordinated set of mental health activities for a defined geographical area with a population of 300 000 - 400 000 inhabitants. The key elements are: coordination, collection of background data ("war-time epidemiology"), capacity building and self-empowerment of local professionals at all levels, as well as a community-oriented approach to mental health care and primary health care.

A new structure to achieve sustainability and continuity of preventive mental health interventions, the European University Centre for Mental Health and Human Rights, is proposed for the medium- and long-term perspective of assistance.

References - Références


