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Mental Health in Afghanistan

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Abstract

Whilst the war in Afghanistan continues, there has been an obvious challenge to the acute medical services to necessarily priorities the demands of on-going illness and injury. In focusing on this, little attention has been given to the effects of the war on mental health. This brief paper aims to highlight the extent of mental illness in Afghanistan, identifying the most common problems and makes reference to strategic considerations for developing services.

Keywords: Mental Health, Afghanistan, War, mental illness

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Preface:

The experience of daily life for the people of Afghanistan whilst living with over two decades of war is well established. The literature is rife with stories of war, occupation, poverty and social decline. The financial and practical aid, though clearly necessary, appears to have had little bearing on the daily lives of a people who are struggling to come to terms with a new identity, whilst managing tumultuous change. Against this backdrop of continual re-development, whilst resilience amongst the Afghani population is high, the on-going crisis has been fuelled by the emergence of ensuing health problems.

A report by the Afghanistan Research and Evaluation Unit 2002 (AREU) emphasised the need for mental health services whilst simultaneously acknowledging that there was little / no development of actual clinical services. The picture unfortunately remains the same in 2011. What little resources are available are used to prioritise physical health emergencies in a setting where the daily causalities of war are ever present. Therefore, currently there are no clinical services in operation to offer psychological support to individuals suffering from mental health problems of any form. This, in turn, has self-evident effects on the contribution those individuals can make to themselves, their families and society at large. The communities are stuck in a viscous cycle; individuals are unable to progress and develop their communities as they themselves are in need of help (either for themselves or some alleviation of their daily domestic responsibilities) from the very communities they aim to help. Given the current political climate this will inevitably have a deteriorating effect at a national level and progress will necessarily be limited in all aspects of society, stunting development as a whole and increasing reliance and so influence on/by external sources. This in turn will only add to further deterioration of mental health since it is widely known that environmental factors are stressors to psychological problems. It seems then that in current day Afghanistan, mental health is a problem for everyone.

Turning then to specific statistics, although the literature is scarce, the latest World Health Organisation report **DATE**: revealed that mental health is now seen as the main health problem in the country. The reported prevalence rates vary, from the WHO (DATE) reporting 60% to 81% (Park, 2002) and even 95 % (Shanley, 2003) of the population suffering from some form of mental health problems. The cause appears to be directly related to two inter-related phenomena; post war trauma and the daily stressors of living in an environment of continual re-generation and re-development.

Clearly environmental factors cannot be ignored in overcoming mental health problems, since they are often the trigger, particularly in diagnoses such as reactive depression and PTSD. Miller, K. et al, (2008a) researched the relative contribution of daily stressors and war-related experiences to several mental health outcomes. They concluded that daily stressors accounted for a greater amount of variance in depression, anxiety, general distress,

and functioning than war experiences. Daily stressors and war experiences contributed equally to levels of PTSD symptoms, with daily stressors moderating the relationship between war experiences and PTSD

Gender Differences

Research findings suggest that women appear to be suffering from mental health problems to a greater extent as compared to men (Miller et al, 2008a, Cardozo, 2005. Rasekh et al, 1998). Miller et al (2008a), in exploring mental health amongst Afghans in general found that men experienced moderate levels of distress as compared to women. Cardozo et al (2005) reinforced these findings, reporting that figures for females and males in Afghanistan with mental health problems were 73% (f) and 59% (m) depression, 84% and 59% anxiety, 48% and 32% PTSD. Their research concluded that overall there was lower mental health status as well as lower social functioning in women as compared to men. Rasekh, et al, (1998) in exploring mental health issues in a sample of 160 Afghani women (80 refugees /80 resident in Kabul) alos concluded that the majority of women reported poor mental and physical health status, with 97% depression, 86% from anxiety and 42 % from PTSD. Razekh et al (1998) suggest that the lack of education, poor or *no* access to health services and lack of freedom of movement has compounded the problem for women since they are arguably more exposed to these factors in post - war Afghanistan, where gender issues is an on-going battle and women feel their rights are being stifled under various regimes.

Strategic considerations

Whilst as Miller (2008a) states, the role of having strong faith in Islam itself has enabled the people of Afghanistan to maintain some form of psychological order, additional practical steps need to be taken to alleviate on-going distress. As mentioned above, trauma does not simply end with the event and such social and political upheaval has consequences. The implications of this situation are poignantly summarised by a question posed by Azmi (2004); how *can a country rebuild itself when its citizens are in need of rebuilding themselves first?* The current resources to deal with the scale of this problem are nominal, with one mental health hospital for the whole country with only 50 beds and 2 qualified Clinical Psychologists. In countries where mental health services are well resources, staff teams may often work closely with families to support patients at home, as Menneschmidt (2005) stated that no such support can be found in Afghanistan, where the care-givers themselves are often exposed to the same difficulties as the patients. Evidently, the impact of the current environment in Afghanistan holds both personal and collective loss, where pre-war issues are compounded by post-war phenomenon; the management of which is precarious to say the least.

A timely strategy is now needed to avoid an impending tragedy. The prevention of illness is becoming all too necessary. A strategic psychological intervention plan at this point would hopefully avoid/ prevent exacerbation

of difficulty and its effects on individual and societal, social and economic responsibilities but will also be extremely cost effective given the limited resources. This in turn would reduce the increased chances of hospitalisation for patients as well as the ensuing drain on individual / governments resources.

The responsibility in such situations has of course traditionally been shared by the international community. This case is no different. Dittman (2003) suggests that in addition to the need for financial donors and health care planning, there is an urgent need to re-establish mental health services since there remains no structure for social support due to the on-going shortage of facilities. Further, as Park (2002) states there is a responsibility upon professionals and co-operation is needed by a range of agencies in re-building resources, training and supervision. This refers equally to the academic side of psychology as well as clinical services since their relationship is inter-dependant.

Establishing and implementing the academic/clinical link.

The current stagnation of clinical services is directly related to the under-pinning lack of available man-power within Afghanistan itself, which in turn is related to the lack of relevant curriculum development. Therefore, whilst it is abundantly clear that there is of course a benefit to external agencies offering input in to academic development of curriculum, the ongoing, financial implications of paying external agencies coupled with the negative security images portrayed by media outside the country make it difficult for input to be readily offered. Both factors are of course, having a wearing effect on draining resources and morale. Further, the input offered may also mean that working clinical models are not developed specifically for the Afghani population but are simply imported from aboard (without consideration to cultural and religious relevance) for ease and speedy implementation. Significantly, research has repeatedly concluded that any future psychological interventions and training should necessarily be developed from within a culture-specific context, sensitive to the needs of this community (Miller et al, 2008b). This has been repeatedly borne out in cross cultural research and applies to all individuals in spite of the fact that the person may be native or a migrant to their host nation, as is cited in Hussain and Cochrane, 2004, Hussain and Cochrane , 2003, Hussain and Cochrane , 2002, Greenwood, Hussain and Burns, 2000 amongst others. Whilst attempts are being made to develop a culturally-sensitive model by Afghani academics, the reliance on external manpower/ support for implementation means their efforts are repeatedly hindered by the contradictions and dilemmas arising from a clash of ideologies, resulting in a repeated failure to progress. Hence, the most long term and effective model would be one of self- sufficiency.

Central to progress is the need for the members of the Afghani population to show their commitment to progress and development of the country. In essence, this means utilising available resources to train individuals

who would be capable of inputting in to the wider training scheme once they themselves have completed their training – at home or abroad. This independence would allow for a culturally and religiously sensitive model of training as well as enable the direct delivery of a clinical service relevant for a population attempting to manage continual change where the power comes from within the people themselves.

Conclusion

The effects of on –going conflict and war have had a serious effect on the levels of mental illness within Afghanistan. Whilst the general prevalence is high, gender differences indicate that the problems for women are more acute than for men. Whilst the extent of the problem has been acknowledged at a national level, there has been no development in providing actual services. In order to offer the most effective service, it is important to be mindful of cultural and religious factors when developing any plan, if mental health services are to successfully meet the needs of the host communities.

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