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## Mental Health in Postwar Afghanistan

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**T**HIS ISSUE OF *JAMA* PRESENTS THE FINDINGS FROM 2 epidemiologically well-designed studies of mental health in communities affected by the war in Afghanistan. The study by Lopes Cardozo and colleagues<sup>1</sup> is the first nationally representative mental health survey conducted in Afghanistan to be reported. The study by Scholte and colleagues<sup>2</sup> examined mental health symptoms among a large sample of mainly ethnic Pashtuns residing in Afghanistan's eastern province of Nangarhar, the seat of the Taliban movement. These studies add to a growing literature on the devastating impact of war on the mental health of civilian populations and to the sparse medical literature on Afghanistan since the Taliban era.<sup>3,4</sup>

Studies of mental health during active humanitarian emergencies are rare and difficult to undertake. The careful attention given in these studies to complex sampling designs among large, representative community samples and the efforts to apply qualitative methods to adapt standard mental health measures are admirable. These studies provide cross-sectional assessments of mental health symptoms in Afghanistan as well as a baseline for tracking population trends in mental health over time.

Both studies were conducted to assess the prevalence of trauma exposures, mental health outcomes (such as symptoms of depression, anxiety, and posttraumatic stress disorder [PTSD]), social functioning, potential risk and mitigating factors for mental health and functional impairments, and coping strategies in postconflict Afghanistan. Both stud-

ies used well-recognized and reliable instruments to determine exposure to trauma and mental health and functional assessments (ie, the Harvard Trauma Questionnaire [HTQ] and the Hopkins Symptom Checklist-25 [HSCL-25]). In addition, the study by Lopes Cardozo et al<sup>1</sup> examined attitudes toward hatred, revenge, and justice. They also examined scales from the Short-Form Health Survey (SF-36), indicative of general health, bodily pain, social functioning, and role-emotional functioning, as well as variations in mental health problems among disabled and nondisabled populations. Among the strengths of the study by Scholte et al<sup>2</sup> are the questions the investigators included to assess resources for emotional support and their findings of variation in both the expression of mental health problems and the availability of different resources for emotional support for women and men.

While both studies provide support for increasing resources devoted to mental health in Afghanistan, the major findings were neither surprising nor new compared with the studies of other war-affected populations referenced in both articles. Therefore, their main value is to inform programming for the populations being studied. Both studies made progress in identifying factors that may be modified by interventions. For instance, the study by Lopes Cardozo et al<sup>1</sup> explored the issue of coping among Afghans with and without disability. For both groups, reading the Koran or praying as well as having more income were among the top 2 sources of coping, followed by talking to friends or

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receiving medical assistance (which was ranked third for disabled respondents). Similarly, Scholte and colleagues<sup>2</sup> observed that religion and family were the main reported sources of emotional support. Insufficient access to medical care was an important stressor in both studies.

While there may be an element of social desirability in these data, the findings could have additional important programmatic implications. The results underscore the general need for interventions that restore a stable and familiar environment, while pointing to those elements of that environment that are most important. These include not only sufficient access to the basics of food, water, shelter, and medical care, but also meaningful community engagements and preservation of personal dignity and hope for the future. Such interventions are psychosocial in that they are aimed at improving the mental status of the general population, rather than identifying and focusing on those with categorical mental disorders.<sup>5</sup>

The data may not be so useful for determining rates of mental illness and informing clinical or focused interventions. The screening tools used by both studies—the HSCL and HTQ—were not originally designed to distinguish between mental disorder and normal reactions to severe environmental stress. For example, most of the symptoms assessed in the HSCL (loss of appetite, feeling sad, difficulty sleeping, loss of interest and energy) might reasonably be expected in someone who has no income, is experiencing a breakdown of normal environmental and social supports, and has extreme uncertainty about the future. Similarly, the symptoms assessed by the HTQ (such as nightmares, feeling detached, jumpiness, irritability, and avoidance behavior) could also be expected in someone who is still living in a highly stressful and dangerous environment. With its recent history, continuing instability and unrest, and a devastating drought, Afghanistan is clearly a highly stressful and dangerous environment.<sup>6,7</sup> Thus, interpretations of the results of these 2 studies must include consideration of whether symptoms reported among the Afghan respondents represent actual psychopathology or a normal response to severely abnormal circumstances.

Although the instruments used in both studies were translated, back-translated, and pilot tested among Afghan participants before their use in these studies, they were not formally validated for use in Afghanistan. The authors of both studies acknowledge this methodologic limitation and note that the instruments have been shown to be reliable in other postwar communities and reference previous work by Mollica et al in validating the HSCL and HTQ among Indochinese refugees.<sup>8,9</sup> However, Mollica et al did this work among refugees living in Massachusetts. While the experiences of Indochinese refugees and Afghans share similarities, the environment in which they were living at the time of their assessment (United States in the 1980s vs Afghanistan in 2002) are so different as to cause concern about applying the cutoff scores and clinical interpretation suggested by Mollica

et al to studies in Afghanistan today. In discussion of the HTQ, Mollica et al stated as much, noting that “for each new cultural setting, the HTQ cannot simply be applied without revisions. . . . Validation studies are necessary to establish the revised sensitivity and specificity of the HTQ for assessing PTSD.”<sup>9</sup>

The careful attention to epidemiological and statistical issues demonstrated in both articles—while providing little evidence of whether the instruments are appropriate for detecting mental disorders locally—is typical of most cross-cultural work using standard instruments. Without local validity, however, and in an environment in which the context and related stressors are dramatically different from that in which the instruments were originally validated, estimates of the local nature and prevalence of mental health disorders in Afghanistan must be interpreted with caution.

While the authors could have done more to culturally validate their instruments among Afghans, the difficulty in using screening instruments to identify mental disorders in a highly stressful environment is another problem that has not yet been effectively addressed. Therefore, the ongoing debate as to the appropriate role of psychosocial vs clinical interventions following a disaster<sup>5</sup> may be moot without the appropriate tools to detect clinical need. However, there are other reasons to prefer a psychosocial approach immediately following a disaster. For instance, improvement in non-specific symptoms would be expected among persons with and without specific disorders and may, in some cases, be enough to reduce symptoms below the threshold of clinical disease. Furthermore, since psychosocial interventions emphasize restoring the physical and social environment, they may be more easily integrated with other health, social, and economic programs with that same purpose.<sup>5</sup> This contrasts with clinical interventions that usually require separate resources and training.<sup>5</sup>

In addition to the difficulty in distinguishing mental disorders from normal responses to stress and trauma, and the widespread need that has been demonstrated by these studies regardless of rates of mental illness, there is a lack of evidence supporting the effectiveness of both psychosocial and clinical interventions. Until recently few clinical trials of any mental health interventions have been conducted in developing countries among the populations affected (or most likely to be affected) by wars, disasters, and other complex emergencies.<sup>10-13</sup> The major objections to conducting intervention trials in such complex emergencies are limited resources and the need to respond quickly to the immediate needs of survivors. As a result, after years of disaster response and development, knowledge of the effects and outcomes of commonly used interventions is still lacking. Indeed, evidence is emerging that some commonly used posttrauma interventions may not be helpful, or may even be harmful.<sup>14</sup> If this happens for interventions developed in the West, how much greater is the uncertainty when such interventions are applied to other cultures?

However, postdisaster intervention research can be conducted in a manner that is both scientifically sound and ethical. If an intervention is applied to a randomly selected half of the target population with the other half waiting to receive the intervention serving as controls in a delayed crossover design, then the delay for those serving as controls in receiving the intervention is only that required for the duration of the treatment and analysis (perhaps a matter of months at most). Then if a specific intervention is delayed until after the immediate postdisaster phase and found to be effective, the effect of this delay should be negligible. If the intervention is found to be ineffective, half of the population is not subjected to a useless intervention and its costs.

This approach was used in a trial of group interpersonal psychotherapy for treatment of depression and dysfunction in Uganda as assessed through locally validated measures.<sup>10</sup> That study began as a programmatic evaluation plan: the implementing staff were to evaluate all participants before and after the intervention. However, by initially restricting the intervention to 1 group per village and randomizing the 30 project villages to intervention or control, data on the relative effectiveness of interpersonal therapy were collected while delaying treatment for those in the control group by only a few months. These data were subsequently used to justify giving the intervention to the study participants in the control group and also to other persons with depression in the region.

In the case of psychosocial programming in the immediate postdisaster period, the approach would need to be different. Where these programs represent variations on reconstructing the physical and social environments (such as an emphasis on those elements supporting resilient mental health profiles identified in the studies by Lopes Cardozo et al<sup>1</sup> and Scholte et al<sup>2</sup>), research would consist of a comparison between programs with a psychosocial component and those without. To the best of our knowledge a controlled trial of a psychosocial intervention using this approach has yet to be reported.

The 2 epidemiological studies of mental health in Afghanistan published in this issue of *JAMA* provide a useful and interesting assessment of the postwar mental health

symptoms in Afghanistan. There are some concerns about the assessment instruments used and whether generalizations about clinical disorders and specific medical treatment can be made. However, these studies provide an initial indicator of psychosocial approaches that might be effective and worthy of future study. When it comes to implementing these and other interventions, where possible they should be done as part of a research agenda to begin to contribute to the sparse data on what is effective in promoting mental health after wars, disasters, and other complex emergencies.

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