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Editorial

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The reason why psychiatrists should oppose war

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The dramatic invasion of Ukraine has forced us to rethink the position of psychiatry and psychiatrists with regard to war and its tragic consequences. Literature reports highlight how approximately 2 billion people worldwide currently live in areas involved in armed conflicts resulting in violence, displacement, infrastructural damage and disruption of public health services, thus producing a negative effect on their health and wellbeing [1]. Death is sadly the most the most dramatic consequence of war. During the 20th century, armed conflicts were responsible for approximately 191 million deaths [2]. Available data underline how the majority of war victims are civilians. Indeed, the rate of 1 in 7 deaths among civilians during World War 1 rose to two thirds of deaths during World War 2, with a further increase to 90% of deaths during conflicts occurring at the end of the 20th century [3,4]. In addition to deaths and other physical injuries, war directly endangers the mental health of those involved. However, exposure to traumatic events (e.g. military attacks) is not the only stressor present in wartime, with mental disorders potentially stemming from a series of other consequences of armed conflicts such as displacement, loss of livelihoods, food and water shortages, exposure to traumatic incidents and forms of violence other than military aggression, loss of protective factors (e.g. family and financial stability) and other forms of migration-related distress, including lowering of socio-economic status [5]. War-related mental disorders comprise not only posttraumatic stress disorder (PTSD) but also other forms of stress-related conditions, such as insomnia, anxiety and depression. Moreover, during wars, individuals suffering from mental health issues are potentially more prone to exploitation and face other health- and wellbeing-related risks [5]. The most recent WHO systematic review and meta-analysis [6] reported a prevalence of mental disorders in populations involved in armed conflicts, assessed at any point in time, of approximately 22·1%; the mean comorbidity-adjusted and age-standardised point prevalence of depression, anxiety, and post-traumatic stress disorder was 13·0% for mild forms and 4·0% for moderate forms; the mean comorbidity-adjusted, age-standardised point prevalence for severe disorders (schizophrenia, bipolar disorder, severe depression, severe anxiety, and severe post-traumatic stress disorder) was 5·1%; all these figures were considerably higher than those obtained for general populations not involved in armed conflicts. Exposure to war-related distress may also produce long-lasting consequences on mental health, as demonstrated in a study of Vietnamese subjects who had been exposed earlier in life to three types of war traumas (death and injury, stressful living conditions, and fearing death and/or injury); the higher level of exposure was associated with poorer health in later-life across a large number of outcomes, such as number of diagnosed health conditions, mental distress, somatic symptoms, physical functioning, post-traumatic stress symptoms and chronic pain [7]. The impact of war on the mental health of

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civilian populations is of particular relevance. Indeed, studies conducted in this field have shown a definite increase in both incidence and prevalence of mental disorders in these populations, with women, children, elderly and the disabled classified as the most vulnerable groups [8]. Civilian populations seeking refuge from conflicts, attempting to escape the direct danger of warfare, experience food insecurity and loss of livelihoods. It has been calculated that almost 40% of the 68.5 million people currently displaced by conflict have crossed international borders, while the remaining approx. 60% are internally displaced people [9]. No less than 4 million Ukrainian refugees are expected to be displaced by the current armed conflict. A review of studies on the long-term mental health of 16,010 war-affected refugees found prevalence rates of depression ranging from 2.3-80%, of PTSD from 4.4-86%, of anxiety disorder from 20.0 and 88% of depression, with average prevalence estimates being typically in the range of 20% and above. The significant heterogeneity of data is due to both methodological and other factors, such as the country of origin of refugees and their destination for resettlement; higher exposure to pre-migration traumatic experiences and post-migration stress were the most consistent factors associated with mental disorders, with a poor post-migration socio-economic status as a factor particularly associated with depression [10]. Data present in literature reveal how both war trauma and post-migration stressors exert a powerful influence on mental health, whilst the post-migration environment seems to play a fundamental role in either fostering or impeding recovery from war-related trauma and grief; moreover, other daily-life stressors related to the experience of displacement, such as social isolation, poverty, family violence, discrimination and uncertainty over asylum status have been acknowledged as relevant factors affecting mental health [11]. Lastly, it should be taken into account that refugees and asylum seekers may frequently have been exposed not only to the consequences of war in their country of origin, but also survived a dangerous journey, struggling with negative reception in transit and host countries [12]. Women, children and adolescents are among the most vulnerable populations during conflicts. Exposure to armed conflicts is associated with increased prevalence of anxiety disorders, such as post-traumatic stress disorder, and depression among children, adolescents, and women, both during and after conflicts. It has been estimated that the average prevalence of anxiety disorders and major depression among conflict-affected populations is two to four times as high as global prevalence estimates, with a large effect of conflict exposure on women's mental health, with several studies reporting a greater effect of conflicts on women than men, often related to gender-based violence [13]. Armed conflict is a negative social determinant of child health, with a certain number of studies documenting how adversity during childhood can alter the architecture of the brain and neuroendocrine function, leading to alterations in learning, behaviour, and physiology, in turn predisposing the developing child to maladaptive behaviours and ill health throughout their life course [14]. Literature indicates regressive, behavioral and cognitive symptoms emerging as consequences of distress, including bedwetting, fear, sadness, aggression, hyperactivity and inattention during the conflict, together with clear-cut syndromes such as adjustment disorders, depression, anxiety and, to a greater extent, post-traumatic stress [15]. Finally, several studies seem to indicate the possibility of a transgenerational transmission of the consequences of war on mental health. Indeed, a study of 1966 adult subjects whose fathers had served in the Australian army during the Vietnam War demonstrated that almost 40 years after the war, the adult offspring of deployed veterans were more likely to be diagnosed with anxiety and depression, featuring suicide ideation, suicidal plans and self-harm behaviours more frequently than the progeny of comparable, non-deployed army veterans [16].

In conclusion, war is one of the most powerful threats to mental health, particularly for innocent victims of conflicts such as civilians. The duty of psychiatry and the psychiatrist is to safeguard the mental health of the population. For this reason, the recourse to war as a means by which to resolve conflicts should be unfailingly and universally rejected - both now and forever.

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