MSF
July 2010

Three time victims

Victims of violence, silence and neglect

Armed conflict and mental health in the department of Caquetá, Colombia

MEDECINS SANS FRONTIERES

Contents

"Every day, when I start seeing patients, I try to understand why our country has been plunged into this sea of violence for over five decades. Today, nearly three years after I started to work on the mental health program run by Médecins Sans Frontières / Doctors Without Borders for people affected by the armed conflict and forced displacement, I realise just how futile this chronic violence is. All of the life stories I have heard in my office revolve around the same issue: stories of pain, death, despair and fear, fragments of lives soaked in a violence so irrational that it shows our fellow human beings are dehumanised and have a cruel nature."

Mario A. Ibáñez Suárez, psychiatrist for Médecins Sans Frontières / Doctors Without Borders in Florencia, Caquetá (Colombia). July 2008.

1 Introduction

The department of Caquetá, the country's southern gateway to the Colombian Amazon, has been one of the focal points of the Colombian conflict. The historical presence of the guerrilla and of paramilitary groups, combined with a strong presence of the military in recent years, has seen the area turn into a geostrategic "battlefield" over the control of transport and of the land itself, which is particularly rich in natural resources and has large areas of illegal crops. The consequences for the civilian population are vast. Threats, murders, forced disappearances and displacements, confinement and restrictions on movement are just some of the dangers that the inhabitants of Caquetá are faced with.

However, the civilian population not only endures the violence caused by the armed conflict. It also faces additional violence on two different levels: the neglect and ineffectiveness of the institutions that ought to tend to them, as well as social silence and stigmatisation. These three levels of violence have a serious impact on the mental health and the quality of life of the individuals and communities which are exposed in one way or another to the conflict. **These multiple forms of violence are the atrocious reality that a large part of the people of Caquetá has to live with, making them triple victims of the conflict.**

The consequences of this violence include a series of mental health disorders, both on an individual and on a family and community level, which overwhelms the population's coping mechanisms and causes severe emotional and psychological suffering which the authorities ought to respond to.

Médecins Sans Frontières / Doctors Without Borders (MSF) has been working in the department of Caquetá since 1999. In 2005, the organisation began to implement a mental health project to tend to the victims of the Colombian conflict and to provide a service that was not being adequately supplied by government health structures.

This report is based on data compiled from 5,064 patients who were provided clinical care by MSF from March 2005 to September 2009. 65% of the patients were female and 35% were male. Ages ranged from 1 to 89, although patients most commonly belonged to the 19-45 year age group. Additionally, 60% of the people were seen in Florencia, the capital of the department, and 40% were seen in rural areas.

Through the statistical data collected and the accounts provided by its patients, MSF wishes to make known the suffering that the violence is causing among the population. **The mental health profile recorded among our patients demonstrates the direct impact of the armed conflict on the mental health of the population, which the country's mental health services fail to cover due to the extent of the problem.**

Finally, this report seeks to demonstrate that **mental health services can indeed be provided in conflict situations, even with limited resources, and that they can effectively benefit patients.**

2

The armed conflict in the department of Caquetá

The department of Caquetá is a geostrategic region which a number of armed groups have fought to control for decades. Since the 1980s, the Revolutionary Armed Forces of Colombia (FARC) have exerted a strong social and military influence in the region, where paramilitary groups are also present.

The peace process between the FARC and the Government broke down in 2002. The subsequent suppression of the "demilitarised zone"[1] brought a dramatic deterioration to every aspect of the conflict. In addition, the militarisation of department has increased further due to the Patriot Plan launched by the Government in 2003 to regain control of the area.

This situation is compounded by extremely high displacement rates. According to government sources, in 2009 Caquetá was one of the Colombian departments where most people – over 7,600 – were displaced[2]. Furthermore, the annual homicide rate almost doubles the nationwide average. In 2009, 265[3] people were murdered in the department, and there were 130[4] incidents involving undetonated anti-personnel mines and other ammunition, which killed a further 20 civilians. One of the reasons for such a high level of exposure to violence of the civilian population is that the parties in the conflict seek to involve them in different ways in an effort to either gain or maintain their influence in the region.

As a result, not only is the population of Caquetá significantly exposed to the dangers inherent to the war, but through the years it has also been subjected to direct and continued interaction with the armed factions and has lived in permanent fear. The situations the people are most commonly exposed to include: direct and indirect threats, murder of relatives, neighbours or friends, massacres, tortures, forced disappearances, kidnappings, arbitrary detentions, landmines, fighting, terrorist attacks, crop eradication, restrictions on staple food supplies and other basic survival items, confinement of communities, sexual violence and forced recruitment, sometimes including minors.

1
Some of the municipalities of the department of Caquetá fell within the demilitarised zone established by the Government from 1999 to 2002 to move peace talks with the FARC guerrilla leaders forward. When negotiations broke down, the Army launched a large-scale offensive forcing the FARC to withdraw, although the guerrilla group preserved its military capacity.

2
The departments where most inhabitants were displaced in 2009 were Nariño, Antioquia, Cauca, Tolima and Caquetá, accounting for 51% of the total number of forced displacements recorded during the year. Colombian Presidential Plan on Human Rights and International Humanitarian Law. *Indicators on human rights and IHL in Colombia. 2009.* http://www.derechoshumanos.gov.co/observatorio_de_DDHH/documentos/Indicadores/obs_indicadores_dic2009_100503.pdf (in Spanish)

3
Op. Cit. Footnote 2.

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3
The work of MSF in Caquetá

MSF has been working in the department of Caquetá since 1999, and has been implementing specific mental health activities since 2005. The organisation's teams currently visit the district capitals of Cartagena del Chairá, San Vicente del Caguán and Curillo regularly to carry out mental health promotion and prevention activities and to provide regular consultations at local hospitals. Mental health is also one of the components that MSF mobile primary care clinics provide in the rural areas around Cartagena del Chairá and San Vicente del Caguán. In addition, MSF also worked for four years in a mental health clinic in Florencia, the department capital. In May 2009, the mental health activities performed in this clinic were handed over to the country's *Universidad Nacional Abierta y a Distancia* (Open University).

As part of its mental health project, MSF provides individual, family and group psychological support, as well as psychosocial activities (informative talks, psycho-educational workshops, basic mental healthcare training, etc.). In addition, the organisation has established community networks to ensure that care is delivered to those who need it most.

The organisation's activities are implemented by clinical and social psychologists, and by prevention and promotion technicians. From March 2005 to September 2009, MSF provided care for 5,064 people in the department of Caquetá.

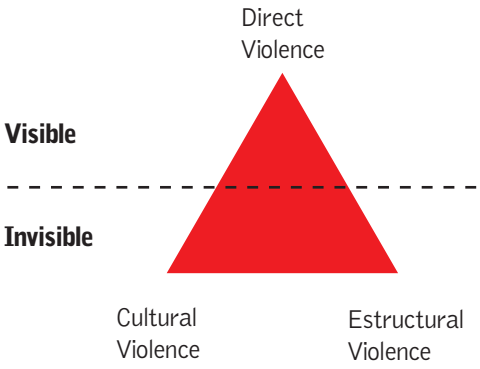
4
Violence, conflicts and health

The World Health Organization (WHO) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation".

As in many other conflicts, the physical and verbal violence in Colombia is self-evident, but the structural and cultural forms of violence, which are no less serious, are harder to perceive. (See figure 1, page 8[5]).

5
See Johan Galtung, *Peace by peaceful means: Peace and conflict, development and civilization*, London, SAGE, 1996; particularly its first part, *Peace studies: basic paradigms.* See also, *Conflict transformation by peaceful means*, by the same author. Geneva, United Nations, 1998.

Adaptation of the Galtung triangle, 1996



a) Direct violence. Violence overtly and specifically applied to a person or group, within a specific timeframe, with visible intentions and results. It is understood as bodily, physical and/or psychological harm which is verifiable and, in principle, evident.

Many MSF patients in Caquetá declare to have been subjected to direct violence, such as threats, beatings, rape, displacement or restriction on movements.

b) Structural or indirect violence. Violence exercised by institutions operating in the social environment. In principle, its impact is less evident. This category includes violence owing to political and economic structures that cause segmentation, social fragmentation, exclusion and/or marginalization.

For example, even though Colombian law ensures free service provision for displaced peoples, it is rarely fulfilled and the population is often subjected to humiliations when trying to exercise their rights.

c) Cultural violence. Refers to the cultural aspects of a group that are used to reinforce and/or legitimise direct and/or indirect violence, through religious (holy war, inquisition, etc.), ideological (demonization of opponents, perceiving AIDS as a type of punishment) and linguistic (racist terminology) mechanisms, either through the media or through educational and/or socialization mechanisms.

As an example, civilians from the demilitarised zone of Caquetá are still systematically depicted as guerrilla collaborationists simply because they live in that area.

The interconnection between these three levels of violence in armed conflicts has been widely described, and it has been proven that they are exacerbated when people become accustomed to them[6] [7] [8].

This interrelation can be clearly seen in the armed conflict in Colombia, where as well as the direct violence, the victims are also faced with structural violence on behalf of the institutions, while living in a society in which violence is validated, accepted and promoted by all of the parties that aim to profit from it.

6
WHO, *World report on violence and health*, Washington, D.C., 2002.

7
Ascher, William. "The moralism of attitudes supporting intergroup violence". *Political Psychology*. Vol. 7. No. 3 (1986). 403 - 425.

8
Ferme, Marianne. "The violence of numbers: consensus, competition, and the negotiation of disputes in Sierra Leone". *Cahiers d'Études Africaines*. Vol. 38. Nº. 150 / 152. (1998). 555 - 580.

Due to these close links between the forms of violence found in armed conflicts, the consequences and effects on the psychological balance of individuals are endured not only by those who are confronted by direct violence, but also by the general population of conflict zones.

5 Victims of violence directly related to the armed conflict

The data analysed below have been compiled from 5,064 patients[9] who were provided clinical care by MSF from March 2005 until September 2009, regardless of whether the organisation classified their exposure to the conflict as direct or indirect. The consultations were provided both at the mental health centre in the town of Florencia and in the municipalities of Curillo, San Vicente del Caguán and Cartagena del Chairá.

Using the data compiled by the project, we performed descriptive analyses and comparisons between the risk factors[10] that the population was exposed to and their clinical diagnoses.

The direct violence related to the armed conflict affecting our patients can manifest mental health disorders or disturbances within a specific range of clinical diagnoses[11], which are described in further detail elsewhere in this paper. In addition to the behavioural disorders that are normally associated to armed conflicts, patients attending MSF mental health services frequently showed adjustment problems and a greater degree of exposure to other forms of violence (familial, sexual or social), which is typical of armed conflict contexts[12].

Furthermore, the direct violence associated to the armed conflict can also be observed in the personal accounts provided by our patients, which regularly include acts of violence such as threats, injuries, forced recruitment, displacement, kidnappings or murder.

9
65% of the patients seen were female and 35% were men. The most common age group was 19-45 years, accounting for 54.9% of all patients.

10
A risk factor is any circumstance or situation that increases a person's chances of contracting an illness.

11
Exposure to the stress generated by war can cause mental disorders such as post-traumatic stress, major depression and generalized anxiety disorder, as well as other forms of anxiety.

12
Hynes, Michelle; et al. "A determination of the prevalence of gender-based violence among conflict-affected population in East Timor". *Disasters*. Vol. 28. Nº 3. (2004). 294 - 321.

49.2% of the 5,064 patients seen by MSF had been directly exposed to the internal armed conflict, having been affected by fighting between armed factions and other acts of violence. The following accounts illustrate some of the episodes of violence endured by MSF patients:

"Things were going well [at the farm]. My wife and I were making progress and our children's needs were covered, despite living very far away from the town. But then things started to get ugly: they increasingly put pressure on us and demanded bigger quotas for the people in the bush, and things got worse when they started to take teenagers and sometimes even kids away.

Then they tried to take my 13-year-old daughter away, but I could not allow that to happen and I got her out of the village. Then they told me they had to get even. They told my wife not to follow them and to wait for three days before going to fetch me. They bound me to a tree and hit me on the head so hard that I fainted.

I don't know how long I was unconscious or why they didn't kill me. Three days later, my wife was allowed to go and fetch me, and she found me covered in ant bites, because they had stripped me down to my shorts. They told her that they didn't want to see us ever again in the area and gave us three hours to leave the farm."

50-year-old man from a rural area in Caquetá

"You know doctor; a year ago those people killed my son. He was 25 and was my right hand man for everything. He used to worry all the time about me and about my mother, who's very old and very sick. His little brother loved him too. He used to help him with his homework and taught him the jobs we did on the farm. I know that they killed him because he refused to join them and because he didn't listen to them when they told him to leave the area. He wanted to stay with us; he was a good boy who didn't like to get mixed up in funny business. But they took him away from me."

Female patient from a rural area of Caquetá

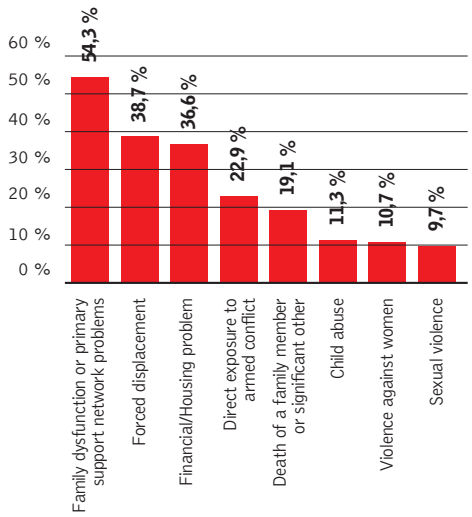
"Things changed very suddenly. We started to see strangers with venom in their eyes. Ever since the rumours about them being in the *vereda*, we had been gripping ourselves for whatever might happen... but we could never have imagined what happened eventually.

One night, the dogs were barking a lot. We got up to find out what the fuss was about and saw a group of men in combat clothes and armed to the teeth who were leading two men who were bound up and gagged. Even though it was dark, we could see the feeling of fear and anxiety in their eyes, as if they were aware of their fate. After a while, two gunshots snapped us out of our astonishment. From that moment on we were unable to sleep; we were petrified by the sound of a chainsaw."

A 50-year-old displaced woman in Florencia

5.1. Risk factors

Most common risk factors



MSF psychiatrists found that the vast majority of patients seen had been exposed to more than one risk factor. **The most common risk factors were**: family dysfunctions or problems in primary support networks (54.3%), forced displacement (38.7%), financial problems and housing (36.6%), direct exposure to armed conflict (22.9%) and death of a family member or significant other (19.1%). In addition, child abuse was recorded in 11.3% of the cases, violence against women in 10.7% and sexual violence in 9.69%[13].

It is important to point out that MSF patients are simultaneously exposed to several risk factors and that some of these factors are directly related to others. As a result, it is not easy to draw clear lines between the direct effects of the armed conflict and other risk factors observed. This can be clearly seen, for example, in the case of "family dysfunctions or problems in primary support networks". This risk factor is defined as: "The individual is in a situation in which s/he has scarce support from her/his next of kin, communication is inadequate, relationships between family members are conflictive or the family structure is seriously disrupted (traumatic separation, sudden changes in family dynamics, etc.)". In a large number of cases in which this risk factor was recorded, the source of the dysfunction was found to lie in life events typical of conflict dynamics: families split up due to displacement or absence (temporary or definitive) of some of its members, which disrupt family dynamics or require an untimely redistribution of family roles.

13 Percentages represent how often each risk factor was observed in all MSF patients.

"I was at school with my sister and my mother was back on the farm with my little brother. When we got home, he was crying and my mother wasn't there. We asked him why he was crying and where mummy had gone, but he couldn't answer. So I searched the house and that's when I found her. I shouted at her to wake up, but she couldn't hear me. Then some neighbours who had heard gunshots arrived and they told me my mother was dead.

A few months earlier, my mother and sister were on a bus that was attacked by armed men. There was a gunfight and my little sister was shot in the head. Luckily, they were able to remove the bullet at the hospital, but now she is in constant pain. After my mother was killed, some men from the authorities took us to live with some relatives because we were minors. But I'm very sad, because my mother is no longer with me and because we left the two dogs we used to play with down by the stream and a cockerel that a friend had given me behind. I don't know what I'm going to do. I used to go to Florencia every weekend with my mother to sell banana leaves, which people ordered to make tamales, and we also took yuccas, pineapples, bananas and other things from the farm, and then my mother would use the money we made to do our own shopping. We can't go to school any more and my father isn't here to keep us company. They told us they've called him but that he's a long way away and that it's going to take him a long time to get back."

14-year-old displaced boy in Florencia

Similarly, a closer look at the cases involving other risk factors, such as sexual violence, family violence or exposure to other forms of violence, reveals that the armed conflict is also behind many of these situations, which include single-parent households, overcrowding of displaced populations in precarious socioeconomic and security conditions or minors in the custody of extended family members.

A similar reading can be made of other factors that, despite not being directly linked to the conflict, are deep-rooted in the conditions it creates, such as "problems in social support networks", defined as: "Situations in which the individual has scarce support from friends, acquaintances, neighbours, community groups and organisations, due to isolation, peer rejection, discrimination or difficulty adjusting culturally".

In such cases, it is not hard to establish the relation between the problems and dynamics of social fragmentation and polarization, fear and mistrust which are typical of internal armed conflicts and/or the social and cultural uprooting inherent to forced displacement. Such is the case in the following account given by a 52-year-old woman who was forced to leave her home in the countryside after

she was threatened by one of the armed factions. Since the army helped her family to escape to Florencia, they are now accused of being informers and have lost part of their social support network.

"We hardly go out any more. We are afraid because those people are everywhere, not just out in the bush. When we do have to go out and we meet people we know from back home, they ask us whether the army is really helping and protecting us, and we try to explain that all they did was get us out of there. But the rumour has gone around the entire area, so we have no hope of going back or sending someone to recover some of our belongings, because this time they would undoubtedly kill us."

52-year old displaced woman in Florencia

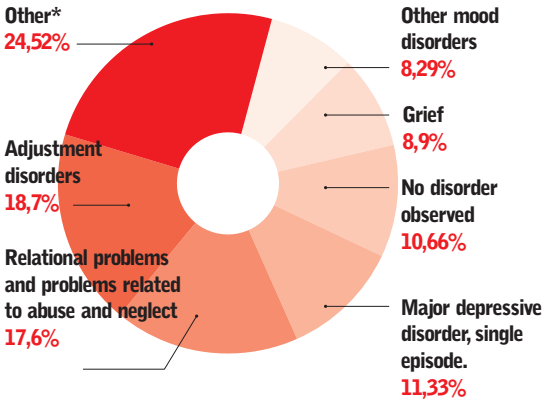
5.2. Diagnoses

The typical clinical diagnoses in war contexts, such as grief or depressive disorders, were common among the 5,064 patients that MSF treated. In addition, it is important to note that the stress inherent to armed conflict situations can also serve as a facilitator for other more serious clinical conditions apparently unrelated to the conflict, such as psychotic disorders[14]. At the MSF project in Caquetá, up to three non-exclusionary diagnoses were recorded for each patient. The one considered most significant in each patient was recorded as the principal diagnosis.

Overall, **the five most common principal diagnoses among MSF patients were**[15]: adjustment disorders (18.68%); relational problems and problems associated to abuse or neglect (17.55%); major depression – single episode (11.3%); grief (8.9%); and other mood disorders (8.29%).

The five most common diagnoses observed imply that over 65% of the people seen did not have a serious or chronic disorder as such, but rather an intense response indicative of acute psychological suffering requiring therapeutic treatment, triggered or closely linked to **devastating external life events**. This is coherent with the armed conflict setting in which MSF was working, with normal, albeit intense reactions to abnormal or extreme circumstances, where therapeutic approaches are essential both to contain and cope with the situation and to prevent more severe and chronic disorders.

Principal diagnoses



* For other diagnoses, see table in Appendix 2.

14 A clinical diagnosis defined by the existence of disorganised behaviour, hallucinations and delusion.

15 As per the categories established by the ICD-10 (International Statistical Classification of Diseases and Related Health Problems). For definitions, see Appendix 1, page 25.

"That's why I'm here [at the Care and Counselling Unit for displaced populations]; because I was told that they could help us here. I came on my own because my husband is ill and my son is afraid to go out. I am also afraid, but I have no choice. You know, doctor, I haven't slept for several nights now. In my dreams in I see the heads of my neighbours. I see them crying, begging for mercy. I wake up in tears. I start thinking about the farms, about my vegetable patch, my chickens and livestock, and about the dogs that tried to follow us until we had to throw stones at them to scare them off.

I'd never felt like this. I'd never seen my husband so quiet; I'd never seen him cry in silence. And what can I say about my son, he's not the boy he used to be. There's no tenderness in his eyes any more, there's anger and there's hatred. I don't know what will become of us now; I only know that we still have God and that our lives will never be the same because now we are displaced people."

50-year-old displaced woman in Florencia.

When an armed group came to her village, she heard them kill and dismember some men, who she was then forced to bury. Finally, when her son was threatened they had to flee their home and escape to Florencia.

Other conditions included behavioural and/or emotional disorders in children (5.76%) and other anxiety disorders (4.28%). 1.5% of the diagnoses were for post-traumatic stress, with acute stress accounting for 1.38%. 10.66% of the patients were not found to have any disorders, which has been described as normal in the setting of mental health consultancies in armed conflicts. It is important to note that patients in whom disorders are not observed are not necessarily healthy.

The above data coincide with other Colombian[16,17] and international studies[18] on the impact of armed conflict on the health of people in whom there is a predominance of depression and anxiety disorders, as well as emotional and behavioural disorders, as was the case in our project. Other common problems include those related to exposure to all forms of violence, to abuse or neglect and disorders specifically affecting children.

16
Londoño N, et al. "Salud mental en víctimas de la violencia armada en Bojayá (Choco- Colombia)". *Revista Colombiana de Psiquiatría*. Vol. XXXIV. No. 004. (2005). 493-505

17
Pérez- Olmos, I; Fernández Piñeres, P; Rodado Fuentes, S. "Prevalencia del trastorno por estrés post-traumático por la guerra, en niños de Cundinamarca – Colombia". *Revista Colombiana de Salud Publica*. Vol. 7. No. 3. (2005) Pág. 268-280.

18
Peña, Y; Mena, M; Hidalgo, T; Mena, N; Adan, E. "La guerra como desastre. Sus consecuencias psicológicas". *Interpsiquis*. (2007) http://www.psiquiatria.com/articulos/psiq_general_y_otras_areas/psiqsocial/28872/?++interactivo (Accessed on: 19/11/09)

Our data analyses revealed that post-traumatic stress disorder was 3.6 times more common among people exposed to risk factors directly related to the conflict than in those who were not. Similarly, acute stress disorder was 2.6 times more common and grief was 2.5 times more frequent among the former group. Adjustment disorders and single episodes of major depression were also more common – 1.6 and 1.3 times, respectively – in people who had been directly exposed.

Analysis of associations between risk factors directly linked to the armed conflict and principal disgnoses. Caquetá mental health project, Colombia. 2005 - 2009.

Diagnosis	Prevalence Rate	Confidence Interval	Mantel-Haenszel chi-square test	P value
Major depression, single episode	1.27	1.09-1.48	9.20	<0.0024181
Acute stress disorder	2.59	1.55-4.34	14.17	<0.0001672
Post-traumatic stress disorder	3.60	2.10-6.16	25.14	<0.0000005
Adjustment disorder	1.60	1.42-1.80	62.46	<0.0000000
Grief	2.45	2.02-2.98	88.99	<0.0000000

Sourse: MSF – España databases

5.3. Clinical outcomes

An analysis of the project's clinical records reveal that **56%** of the 5,064 patients treated by MSF, both in rural and urban settings, **showed clinical improvement** compared to their baseline condition before consultation.

It is important to note that the presence of several active armed factions in Caquetá makes it impossible to guarantee the continuity of mental healthcare provision in the department's rural areas. MSF teams therefore chose a single-consultation strategy in order to improve the therapeutic impact of the care provided, since the likelihood of seeing patients after their initial consultation was scarce.

A formal evaluation performed by MSF on the **immediate effect of the therapeutic single-session intervention** revealed that **94.4% of the patients considered that the approach had been useful to help them address the issue for which they had sought help**. The psychologist working on the project considered this had occurred in 92.8% of the cases. This positive perception was shared by both patient and psychologist in 86% of the cases.

6

Victims of silence and stigmatisation.

Cultural violence

As previously established, not only is the armed conflict in Colombia a risk factor for mental health in itself, but it also creates the conditions for other risk factors that contribute towards the deterioration of the health and quality of life of the people and communities involved.

In addition to the consequences of direct violence, the victims of the Colombian conflict also endure the consequences of indirect violence, including social stigmatisation and silence, which increase the vulnerability of the victims and hinder their emotional recovery.

The stigmatisation surrounding the victims of the conflict in Colombia forces them to bear their situation and suffering in silence, both for fear of the armed factions and the lack of protection they are given when threatened, or due to the shame of acknowledging their situation, since society tends to blame them for their own suffering and considers them responsible for the appalling situations that they are subjected to.

"I now live in a shack in a dangerous neighbourhood. In the mornings I sell bananas off a cart and in the afternoons I work as a loader at the market. But that doesn't cover all my expenses. Things are very different here. Some people look at you as if you were from another planet; they think that if you've been displaced you must have done something wrong. They probably even think you deserve it, but they never ask what they did to you or why you had to come here."

Displaced man in Florencia

He was forced to flee after witnessing fighting between armed factions in his village. When one of the groups finally occupied the area, he witnessed a person being murdered and dismembered.

"Some time ago, I had to flee to Bogotá. We left the *vereda* where we used to live close to Florencia when my brother was murdered. He was tortured; they tied him up and they burned his face with acid. I recognised him in the morgue because he was wearing a shirt I had mended for him. He was so young, he was 25 and his girlfriend was expecting a child.
We suffered a lot in Bogotá. Life is very difficult there, people look at you is if you were from another planet, but we put up with it because there was nothing else we could do."

Displaced woman in Florencia

She moved back to the countryside from Bogotá to work in the fields, but the presence of armed groups forced her to flee again, to Florencia this time.

The above is illustrated by the analysis of the data from the Caquetá mental health project, as 33% of the displaced people attending consultation were not registered as such[19]. One of the reasons for this sub-registration is that some of the people displaced are afraid to speak publically about their situation, leaving them to face their situation without any government support.

The victims of the conflict also have to live with the labels they are given by their original or host communities. On the one hand, they are stigmatised in relation to the conflict: "they are guerrilla members", "collaborators", "informers", "they must have done something", etc. On the other, they are perceived as a threat or as a problem, and people link them to crime or other social problems: "thieves", "drunkards", "they're taking our jobs", etc.

"I worked a farm for 13 years. I had a lot of animals and worked the land. They were good times but, you know, the blasted war came along and ruined it all. In the countryside, we don't slam our doors in anybody's face – armed groups arrive and, without even asking, they stay as long as they like and use everything as if it was their own, and then they leave. Another group comes along as soon as the previous one has left – it's almost as if the devil had tipped them off. And that's where the problem starts. They accuse you of being a collaborator. When you ask how you can be a collaborator if nobody asks your permission. They are fully aware of how things work, but they don't want to know, they just tell you to drop everything and leave. It's the last straw; they even ask you if you want to die. At that point, you remember what happened to so many people you knew; you know they mean it and that your only choice is to get out. You can't reason with them and you choose not to put your life on the line."

Displaced man in the municipal capital of San Vicente del Caguán

19
It is the Government who decides which people are considered displaced. The problem is that the complexity of the system, the fear of those eligible to request displaced status and the Government requisites– which are often oblivious to the reality of the conflict– create a sub-registration of displaced people and leave many to cope without any government support whatsoever. In order to be granted displaced status, a person must provide an account of the events that caused his/her displacement before one of the established state bodies (legal registry, ombudsman, etc.). In turn, these bodies send the information to the Presidency of the Republic's Social Action department, which examines the report and decides whether or not to grant the person and his/her family displaced status. People 'certified' as being displaced are entitled to support such as humanitarian relief aid and are awarded priority in certain government programs concerning education, employment or housing for example, and are automatically provided free access to healthcare. Uncertified displaced persons who do not comply with government criteria face a long and complicated process during which they are denied health coverage, compounding the vulnerability to which they are already subjected to in the towns they have fled to.

Silence and stigma bar any chance the victims have of having their status recognised by society, preventing them from developing any sense of belonging or identity. Since social integration is non-existent, they are unable to adjust to the environment or overcome the traumatic events they have experienced. The poverty in which conflict victims – particularly displaced persons – are forced to live in the host cities makes them extremely vulnerable. The lack of social integration further complicates access to employment, housing, education and healthcare and makes them lose any hope of being able to restore their social, financial and emotional status one day.

7
Victims of government neglect and institutional ineffectiveness.

Structural violence

The way in which the institutions treat the victims are proof of their exclusion by the government. This is apparent in the sub-registration of forced displacement in Colombia, the lack of specific government welfare and healthcare services for the victims of the armed conflict and the scarce allocation of government expenditure to address the issue.

7.1. Lack of recognition

The Colombian Government refuses to acknowledge the armed conflict itself and prefers to speak of a complex emergency or of an anti-terrorist struggle, and this denial also implies its lack of recognition for the victims.

As a result, despite the tremendous problems posed by the forced displacement and other forms of victimization caused by the armed conflict, there is considerable controversy regarding the number of displaced persons, and efforts are made to justify and conceal the problem.

One of the direct results of this failure to recognise the armed conflict and its victims is the lack of social spending allocated to help them, which translates into a lack of adequate and appropriate government response systems.

In the department of Caquetá, these deficiencies are made obvious by the state of the main government office for providing assistance and guidance to displaced persons – the *Unidad de Atención y Orientación*[20] (UAO). Here, displaced persons have to provide a *declaration*, an account of the events that led to their displacement, which is a requisite for them to be granted access to Government support programs, including free healthcare. The deficiencies of this government office are apparent in both the qualitative and quantitative aspects of its infrastructure and its human resources.

The facilities are small, lack privacy and are located in a building that is not even owned by the town council, meaning the council cannot invest in improving them, despite the fact that several NGOs have offered funding. The inadequacy of the facilities and poor staff profiling, overworked personnel or the mere fact that they do not perform the tasks they ought to, mean that the services provided re-victimize the subject. Victims lack any form of privacy when providing their accounts and are submitted to an undignified treatment during the long wait required before being granted access to the services.

"This is extremely hard. I arrived at 3 a.m. to queue up for a declaration form, but at eight o'clock they told us that they would not hand the forms out today. I have to try again in eight days' time. Well, I suppose I don't have a choice, but I have been trying unsuccessfully for 20 days now.

It's an absolute nightmare. Twenty-four days ago we were forced to flee our home along with seven other families because we had all been threatened. What you see now is all I have – nothing – because we weren't allowed to take anything with us. We had a farm, animals and crops growing in the fields and we had to leave them all behind.

But the saddest thing of all is that they killed my 21-year-old son. He was a good boy, not because he was my son, but because he really was, he loved to work with the community."

Displaced man in Florence

20
These units were created under Law 387 of 1997, with the aim of improving the quality of services provided to displaced persons by: facilitating access to local government services offering comprehensive assistance (education, health, housing and employment, among others); to facilitate access to comprehensive, clear and timely information; and to provide personalised and humanised assistance. This UAO ought to comprise a number of government bodies such as the Mayoralty (who is responsible for its running), Social Action, Registrar, Ombudsman or the Solicitor's Office. In addition, there are sporadic visits from the Servicio Nacional de Aprendizaje (National Further Education Service) and the Instituto Colombiano de Bienestar Familiar (Colombian Family Welfare Institute). Visits to the Florencia UAO by representatives of these institutions are extremely irregular.

Many of the people who visit the UAO are in extreme need. They are often forced to flee suddenly, and are not even given time to collect the basic items they need to survive. In addition, they are often explicitly warned not to report the situation.

The lack of political will to respond to the needs of the conflict victims is also reflected in the lack of health services adapted to the reality of the town of Florencia, the department's main host town for displaced people.

There is only one government-run psychiatry unit in the entire department of Caquetá (404,896 inhabitants[21]). The María Inmaculada secondary level hospital in Florencia has a mental health unit with just one psychiatrist and 20 beds for hospitalising acute patients until they are stabilised (maximum stay 30 days). This means that all the unit can do is stabilise chronic psychiatry patients during acute stages; interventions are basically psychopharmacological, and patients are discharged without medication. Other than the limited psychiatric care provided at the María Inmaculada hospital, mental health prevention and promotion services and psychotherapeutic care (which is more appropriate for addressing the psychosocial consequences of the conflict) are nonexistent, underlining the fact that the conflict's consequences on the mental health of the population are systematically ignored and neglected.

"I had not felt well for some time. Whenever I managed to see the doctor, all he did was prescribe pills. That's all. One day I went to the village next to the river to see the doctor there. He examined me and told me I had a mental health issue that required psychological help. I had to come to terms with the fact that I might never be able to go to see a psychologist, because I couldn't afford it."

Displaced woman in Florencia

Government bodies often argue that they do not provide mental health services for the population in the areas directly affected by the armed conflict either because their teams cannot access those areas or because the rural population is unaccustomed to psychological care and would reject the services.

21
2005 Population Census, National Administrative Department for Statistics of Colombia, 2005.

The data compiled by MSF in Caquetá prove the opposite. Psychological care is indeed well accepted by the rural population affected by the conflict. MSF saw 5,064 patients during the study period. Almost 40% of all consultations were provided in rural areas by mobile clinics deployed every 5-6 weeks.

It is logical for the population affected by the conflict to be wary of talking about their experiences. Their silence and distrust are survival mechanisms used in response to the general climate of suspicion surrounding the conflict. Nevertheless, our experience in the field has demonstrated that there is indeed a high demand for mental health services and that the strategies used must be adapted to the complexity of the context.

Considering also that the analysis of our clinical records revealed that the clinical condition of 56% of the patients treated by MSF improved, we can conclude that the chosen approach is indeed feasible and that the provision of mental health services for rural populations affected by the war should be encouraged and expanded.

7.2. Contradictory legislation and lack of expenditure

Colombian legislation aimed at responding to the needs of the victims is fragmented and diffuse. This is compounded by the fact that its health-related aspects often contradict the global social security and healthcare framework set establish in Law no. 100 of 1993. As an example, many of the benefits granted to female victims of sexual violence or forced displacement through current legislation or by Constitutional Court rulings cannot be delivered because they are not included in Law no. 100. Furthermore, the legislation in place can barely be implemented due to the lack of resources allocated to this end.

"I didn't want to demand my rights as a victim of displacement before because I didn't think it was important, but now I realise that I can and that, as a health worker, I can expect to be granted certain assurances. But it's extremely difficult, especially because I was displaced several years ago and these claims are subject to legal impediments and deadlines.

At least I've applied now, but it's been very difficult because there has been no stability at all down the years. We are now fighting for my daughter to be granted medical services and to be admitted to a Family Welfare program, but it's been very complicated because she was born several months after we were displaced and it's almost impossible to add her to the family group in our declaration of displacement. I've had to submit several Petitions of Rights [a specific request made to a public body,

either in the personal or public interest] because the institutions that are supposed to compile the information on displaced populations refuse to do so and ignore their responsibilities towards displaced persons. Fortunately, I'm aware of how the system works, but I often think about all the country folk who can barely read and are scared to speak to the authorities. I can't imagine how they treat them considering how they treat people with formal qualifications.

Now, I am submitting an *Acción de Tutela* [a writ requesting the protection of a constitutional right] because my son is being refused an operation at the hospital. Every time we go, they come up with something new, saying he needs a certain examination, or that the doctor's out, or that we have to pay, or go to a specific office, that the surgeon is not under contract... They make up all sorts of excuses to bore you into giving up, but I know that they're violating his right to healthcare, so I won't give up."

Displaced man in Florencia

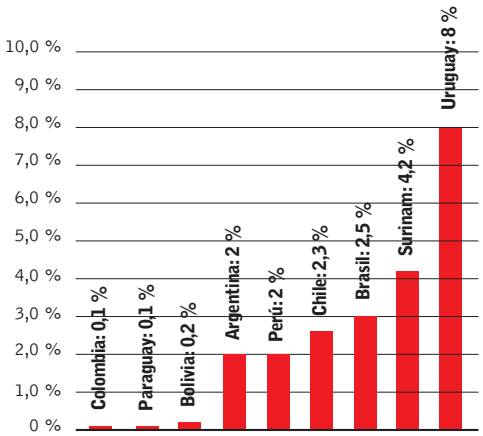
The situation is particularly critical in the field of mental health, which has been neglected for years. This can be seen in the lack of mental health interventions provided for in Law no. 100, which emphasises acute care for chronic disorders and ignores specific actions to provide for the psychosocial needs of populations submitted to armed conflicts. Such is the case of this 52-year-old woman who had to leave her home after being threatened by an armed group.

"I became ill – maybe because of all the anxiety of feeling hunted like an animal, of knowing that I had lost everything – even my clothes – and of thinking that they could find me at any time. My nephew urged me to see the doctor, but the doctor couldn't see the problem, he said: 'No dear, there is nothing wrong with you – you need a rest." And I could not tell him about my problem. It's hardly surprising that I felt so bad, is it?"

52-year-old displaced woman in Florencia

The current legislation clearly excludes all individual psychotherapy, psychoanalysis or prolonged psychotherapy except for individual supportive psychotherapy during the critical or initial phase of the disorder. The critical or initial phase is defined as lasting a maximum 30 days as of the onset.

Percentage of South American health budgets allocated to mental health 2005*



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Policy Committee of the Colombian Association of Psychiatry. "*National Policy in the Field of Mental Health: The Driving Force for National Development and Ensuring Rights*" (in Spanish). Ministry for Social Protection. General Directorate for Public Health. December 2007. Pg. 26. http://www.psiquiatria.org.co/BancoMedios/Documentos%20PDF/politicanacionaldesaludmental.pdf

All of the above problems can be found in the implementation of mental health policies in the department of Caquetá, which fail to provide any real individual or relational emotional support during a crisis.

Comparing regional expenditure, it is particularly striking that the country that allocates the smallest portion of its resources to mental health is the only one where there is an active armed conflict.

As a result, the capacity of the department of Caquetá to respond to the population's mental health needs is clearly insufficient due to poor legislation, poor implementation of national policies and to the lack of political will, funding and qualified staff.

8 Conclusions

Médecins Sans Frontières / Doctors Without Borders is a direct witness of the impact of the armed conflict on the mental health of the population of Caquetá. Based on its experience in the field, MSF has reached the following conclusions:

- The epidemiological profile[22] of the patients treated at the MSF mental health project in Caquetá, based on the diagnoses recorded, is typical of a country in armed conflict.
- MSF patients who had been directly exposed to risk factors related to the armed conflict were more liable than other patients to present diagnoses typically found in war contexts, such as depression, anxiety disorders or grief.
- **49.2% of the patients seen at the project had been directly affected by the conflict.** The armed conflict also generates risks for the mental health of the rest of the population.
- Not only is the armed conflict in Colombia a risk factor in itself for the people exposed to it, but also creates conditions for the emergence of other risk factors that contribute to deteriorating the health and the quality of life of the affected people and communities.
- In armed conflict contexts such as the one in Colombia, **the links between direct, structural and cultural violence cannot be overlooked,** since these forms of violence feed into each other and are interconnected.

All of the above highlights the significant need for specialised mental health services for the population directly or indirectly exposed to the armed conflict. Based on its findings, MSF asserts that:

- It is possible to gain access and effectively provide quality mental health services to the population affected by the conflict.
- Regardless of whether or not the continuity of the provision of therapeutic services can be guaranteed due to the restrictions on access linked to the armed conflict, there is evidence that they have a positive effect on patients' mental health.
- Our project recorded a high demand for mental health services, both in the population affected by the conflict and in other vulnerable groups. **This demonstrates that the need for this type of care is not being addressed by the public structures in the area.**

There is a **clear need for mental health services that are both accessible and adapted to the conditions and needs of a population submitted to the hardships of the armed conflict.**

22 An epidemiological profile is a collection of conditions and ways of life of a population group that leads to a series of diagnoses, which in turn establish the main causes of mortality and morbidity among that population.

9 Appendices

<u>Appendix 1:</u> Definitions for the five most common principal diagnoses. (Based on ICD-10 classification)

Adjustment disorder. This disorder is characterised by the onset of emotional or behavioural symptoms in response to an identifiable stressor within a 3-month period after the stressful event. Its clinical manifestations are greater-than-expected distress in response to the stressor and a significant deterioration of social activities or daily routines.

Relational problems and problems related to abuse or neglect. Relational problems include patterns of interaction between or among members of a relational unit that are associated with clinically significant impairment in functioning, or symptoms among one or more members of the relational unit, or impairment in the functioning of the relational unit itself. These problems can exacerbate or complicate the treatment of a mental disorder or physical illness of one or more members of the unit; they can be caused by a mental disorder or by a medical illness; they can be independent from other disorders in the same subject or can occur without any other concurring disorder.
Problems related to abuse and neglect include categories that are used when the subject of clinical attention is a person seriously abused by another, either through physical abuse, sexual abuse or neglect, both in adults and in children.

Major depression, single episode. Characterised by the presence, for at least two weeks, of at least 5 of the following symptoms: depressed mood, dysphoria or irritability for most of nearly every day; anhedonia or a marked decrease of interest or pleasure in nearly all activities, for most of nearly every day; loss or gain of weight or appetite; difficulty resting properly, either through sleeping too much or too little; agitated or retarded motor activity; fatigue or weakness; recurrent feelings of self-worthlessness or guilt; reduced intellectual capacities; recurrent thoughts about death or suicidal ideas.
The above applies in the absence of criteria for mixed affective, schizoaffective or schizophrenic disorders. The condition has negative repercussions on the patient's social or working life or other personal functioning. The symptoms are not explained by the intake of toxic substances or medication or by an organic disease. The disorder cannot be explained by grief in reaction to the loss of a person who is significant for the patient.

Grief. Normal bereavement initiates due to the death of a loved one, either immediately or several months after the event. Its most common signs and symptoms are: sadness, persistent memories of the deceased person, crying, irritability, sleeping disorders and difficulty concentrating. It does not normally last longer than 6 months, though duration varies from one individual to another.

In some cases, normal bereavement processes can lead to major depressive disorders.
According to ICD-10 classification, bereavement reactions are only classified as adaptive disorders when their duration, intensity or content are not normal; otherwise the reaction is classified as normal grieving.

Mood disorders. The main disturbance in these disorders is a change in mood or affections, normally tending towards depression (whether or not accompanied by anxiety) or euphoria, usually accompanied by changes in the person's general level of activity (vitality). Most other symptoms are secondary to these changes in mood and vitality or are understandable in that context. The majority of these disorders tend to be recurrent and the onset of each episode is generally related to stressful situations or events.

Appendix 2: Table of diagnoses

Principal diagnoses in the Caquetá mental health project in Colombia. 2005 – 2009.

Type of diagnosis	Main (n)	%
Major depression disorder, single episode	574	11.33
Recurrent major depression disorder	50	1.00
Bipolar disorder	48	0.94
Other mood disorders	420	8.29
Acute stress disorder	70	1.38
Post-traumatic stress disorder	76	1.50
Panic disorder (anxiety) with and without agoraphobia	15	0.29
Other anxiety disorders	217	4.28
Adjustment disorder	946	18.70
Somatoform disorders	16	0.31
Dissociative disorders	1	0.01
Factitious disorder	0	0.0
Childhood behavioural and/or emotional disorders	292	5.80
Specific developmental disorders	95	1.87
Pervasive developmental disorders	2	0.03
Childhood anxiety disorders	30	0.60
Mental retardation	89	1.75
Schizophrenia and other psychotic disorders	47	0.92
Organic mental disorders	33	0.65
Substance-related disorders	29	0.57
Sexual identity and gender disorders and paraphilias	19	0.37
Eating disorders	3	0.05
Sleep disorders	12	0.23
Personality disorders	5	0.10
Impulse control disorders not classified in other sections	8	0.15
Drug-induced disorders	3	0.05
Grief	451	8.90
Relational problems and problems related to abuse or neglect	889	17.60
Suicidal ideation/gestures and attempts	4	0.07
Other problems potentially requiring clinical care	35	0.70
Unspecified mental disorder	25	0.50
Other disorders (e.g.: Axis III medical conditions)	20	0.40
No disorder observed	540	10.66
Total	**5,064**	**100.00%**

Source: MSF – España Databases