Post-War Mental Health, Wealth, and Justice

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Abstract

The paper launches a normative debate on an under-assessed health policy problem, namely post-war mental health. It explores its ethical dimensions and argues for a strong moral claim to invest in it as a form of reparation that must be added to the jus post-bellum's truncated list of recommendations. Many countries are currently involved in armed conflict and many more still recovering from past wars. These generally belong to the low-to-middle income group that spend minimally on social and health expenditures. The problem worsens post-war for these countries are burdened with an increased prevalence of mental health disorders with far-reaching repercussions. Failure to recognize in particular war-related psychosocial sequels could weaken capacity to recover and may contribute to a nation's socio-political unrest that could perpetuate throughout generations. The paper argues that reconstructing war-torn societies should be achieved by rebuilding first and foremost the shattered individual. Policy-makers have a stronger positive obligation to invest in post-war mental health because of a shared responsibility for the harm inflicted. This consequently means a shared responsibility in building a sustainable and viable post-war 'minimally just state'. The paper draws on Pogge's 'relational conceptions of justice' and the concept of 'shared responsibility' used in contemporary environmental discourses. It challenges the old paradigmatic model of the just-war tradition which views the world as an archipelagos of well-delineated, self-contained and atomized actors. It also aims to set the stage for an 'ethics of post-war mental health' in line with what Ricoeur calls 'an ethics of memory'.

> Only the dead have seen the end of war.
>
> —Plato

"All mankind . . . being all equal and independent, no one ought to harm another in his life, health, liberty or possessions" writes John Locke (1956). However, the normative dimensions of war reparations and compensations have so far focused on "life, liberty and possessions" excluding health per se. Although the World Health Organization (WHO) and other nongovernmental organizations involved in postconflict reconstruction have recognized the importance of health, and mental health in particular, as a "potential contributor to peace," the current post-war discourses and political theories still exclude that fundamental aspect.

Many countries are currently involved in armed conflict and many more still recovering from past wars. Most of these countries belong to the low- to middle-income group that spend much more on military and weapon expenditures then on social and health expenditures; with less than 1% of their health budgets allocated to mental health (Foege, 2000; WHO, 2006). The problem worsens post-war, for these countries are burdened with an increased prevalence of mental health disorders that has far-reaching repercussions, be it on the societal, economic, developmental, or indeed political level (Danieli, 1998; Levy & Sidel, 2000).

In this article I focus on the mental health and well-being of the civilians whose countries/societies are involved in war and armed conflict, an aspect which is frequently absent in the post-war discourse of the just-war tradition; the so-called *jus post-bellum* (Latin for "justice after war"). Many have advanced arguments for a right to mental health care and a positive obligation for states and governments to ensure mental health care services. Health is indeed a basic human right. There is a positive obligation for states and governments to provide and ensure that mental health care is given the same priority, care, and provision as physical illness as it is indispensable for the well-being of both the individual and society at large (WHO, 2003, 2008).

The normative justification for mental health care has been traditionally formulated along three ethical frameworks: (a) Kantianism views every single life as worthy of

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equal concern, respect, and accordingly equal treatment—the individual is seen as an end and not merely as a means to some other social goal (Kant, 1997); (b) Egalitarianism views health as a "social good," based on Rawls's theory of justice, more precisely the "principle of fair equality of opportunity" (Daniels, 1985; Rawls, 1999); and (c) A right-based approach views health as a basic human right which transcends regime intricacies and moral claims (Gostin, 2001).

Though fundamental for the kind of argument promulgated, these frameworks are incomplete. Kantianism has often been used to argue for "separate spheres" in health (Brock, 2005) which this article opposes. Rather than depicting them as "separate," this article views health and opportunities for "well-being" as intricately related to the sociopolitical fabric of a given society. Daniels' (1985) egalitarian view of a just and right health care system is also "truncated" (Green, 2000); it excludes, for instance, certain mental care services this article considers important. And finally, although a right-based approach is perhaps the closest to the kind of argument I wish to develop, it bypasses the normative dimensions which I think are equally essential for achieving what could be termed an *ethics of post-war mental health* in line with what Paul Ricoeur calls "an ethics of memory" (Ricoeur, 1999). This amounts to an ethics that legitimizes the healing of the shattered self and its shattered identity through a mixture of processes that allow not only cathartic remembering but also forgetting. This kind of possibility to restore or invest in psychological and mental health—rather than merely "erase" unwanted and painful memories (for more on that see Abi-Rached & Dudai, 2009) could substantially contribute to a culture of "just memory" (Ricoeur, 1999). It offers the possibility to work hard on rebuilding the fragmented individual and community through the traces of the traumatic event, while most importantly divesting from anger, violence, and hatred.

Just-war theories (Walzer, 1977) more blatantly failed to incorporate health-related concerns. Recent attempts have been made to emphasize the need for an expanded *jus post-bellum* (Orend, 2006). Yet the list of reparations still excludes the physical and mental well-being of civilian populations (the focus of this article). I therefore propose to analyze this deficiency in the post-war discourse through a combination of two approaches namely the "relational conceptions of justice" formulated by Thomas Pogge (2004) and "contemporary discourses in environmental justice" advanced by Robert Goodin (1995) and John Dryzeck (2005). I argue that war, like poverty or global environmental damage, is a global concern that should be tackled in terms of shared responsibility. The latter entails building in the post-war reconstruction phase as viable and sustainable "Minimally Just State" (Orend, 2006), a concept that is rapidly becoming the cornerstone of the new discourse on *jus post-bellum* and global civil societies.

Why Post-War Mental Health?

Though not explicitly mentioned in the list of "central human capabilities" developed by Martha Nussbaum and Amartya Sen (1992), it could be argued that many of the capabilities mentioned—life, imagination, thought, practical reason, and so on (Nussbaum, 2007)—require a modicum of mental well-being. A reasonable level of functioning and autonomy is required to meaningfully engage in the political and social life (Gostin, 2001). In that respect, human rights are essential for mental well-being.

However, some might argue that there is no need to remedy exclusively the "psychological self" affected by the trauma of war because mental health is "embodied." In other words, they might argue that there is nothing "mental" per se. A mental life is an embodied, indeed a somatic life. Accordingly, they might say, war reparations that attempt to "remedy" some physical damage would implicitly also target the mental or psychological aspect that has been damaged. Clearly, physical health and mental health go hand in hand but very few psychiatrists and mental health workers would today deny the "organicity" of psychiatric conditions. Here, we are dealing with an increased prevalence of severe war-related psychiatric conditions, many of which are associated with long-term morbidities and mortalities such as depression, panic, and anxiety disorders conduct disorder among the young, and substance abuse (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). If these psychosocial sequels are particularly ignored, it is because of their broad and long-term effects that are not necessarily visible and that are clearly more difficult to assess, particularly in underdeveloped or developing countries whereby they frequently go underreported (Ugalde, Selva-Sutter, Castillo, Paz, & Cañas, 2000). Moreover war-torn countries do not invest in war-related mental health problems because of lack of resources and policy planning, mismanagement and corruption, to mention a few reasons. Because there is no explicit positive obligation for countries involved in violence, combats, or wars, to invest in post-war mental health care such an endeavor is relegated to acts of good will and of humanitarian concern.

War-Related Psychiatric Disorders, Whose responsibility?

Despite the many international humanitarian laws and conventions to spare noncombatants, most conflicts since the end of the Cold War until present days share striking characteristics: (a) they belong to low- to-middle income countries, (b) they create catastrophic public health emergencies, and (c) they affect mostly civilians and vulnerable populations—children, adolescents, women, and the elderly (Burkle, 1999). In all the different scenarios of modern warfare, civilians are invariably psychologically and physically harmed,

whether on the aggressor or the victim's side, the defeated or the victor's side.

Though they are supposed to be spared, civilians are the ones who pay the heaviest toll in terms of casualties, long-term morbidity, and mortality (Levy & Sidel, 2000). First, modern warfare is increasingly and invariably associated with high "collateral damage" because most current wars are fought in cities, that is, in heavily crowded areas where most vital civilian infrastructures are located (Levy & Sidel, 2000). Second, these wars involve high technology weaponry with devastating results (Geiger, 2000; Yokoro & Kamada, 2000); one strategy called "bomb now die later" is often used to target vital facilities while avoiding the stigma of deliberate attack on noncombatants (Geiger, 2000). Third, modern wars are typically asymmetric, with the attacked country being either a failing state harboring distributed guerrilla type fighters who know well the territory or another form of rogue government. On the one hand, the attacked state is poor. Whereas on the other, the aggressor does not want many casualties (for fear perhaps of international repudiation) and therefore relies heavily on missiles and euphemistically called *surgical* bombing trying to hit strategic (vital) targets often located in cities. Moreover, people continue to suffer from high levels of insecurity and fear as a result of human rights violations, crimes, and instability even after a peace agreement has been reached (Gostin, 2001). Furthermore, most of these civilians were already suffering antebellum from socioeconomic, political, and health inequalities because the attacker state is in most cases poor. Indeed civilians of these countries are most of the time the victims of bad decisions and policies, government abuse, and mismanagement, suffice to mention the despotic regimes in Zimbabwe, Democratic Republic of Congo, or Iraq under Saddam. Finally, most of these war-torn countries spend very poorly on mental health expenditures with worsening post-war budget allocation because of other priorities (Foege, 2000; Patel, 2007).

For all these reasons, it is not surprising that there is a prevalent sense of injustice and guilt feeling toward the politicians and government officials who are responsible for the decision of going into war. As an example, a research done in former Yugoslavia showed that almost 80% of the civilian survivors reported a "sense of injustice" and perceived lack of redress for their trauma partly owing to perceived impunity for those responsible for the trauma (Basoglu et al., 2005). There is a widespread feeling of impunity and that an unjust harm has been inflicted to the civilian's "integrity" and "dignity" as autonomous, free, rational, and equal agents. So one is prompted to ask, who is responsible for the war-related psychological costs caused to the civilians? Does the responsibility fall only on the government officials of the aggressor side, on all warring parties and/or on the international community, or is it the collective responsibility of the aggressor state?

Strong Moral Claim for a Global Involvement in War-Related Psychiatric Costs

I will now argue that war, just as poverty and global climate change, is a global concern and not a state of affairs confined to well-defined actors as commonly depicted. The two arguments are drawn on Pogge's (2004) "relational conceptions of justice" and arguments in environmental politics. The new perspective that I am proposing widens the somewhat narrow understanding of the factors contributing to war and therefore widens the responsibility for its consequences. There are two justifications for this: first, the international community participates albeit indirectly in the conditions that lead to war; second, there is an interdependency within the international community and thus a distributed responsibility among its diverse members.

According to philosopher Thomas Pogge, the strength of our moral reasons to prevent or mitigate a certain medical condition, for instance, does not solely depend on "distributional factors," that is, in terms of how badly off the person suffering from a medical ailment is, how costly the treatment is, and so forth, but on "relational factors," that is, on how "we" are related to the condition these individuals are suffering from. For example, individual X has stronger moral reasons to mitigate the medical condition caused to Y, if X is materially involved in causing or bringing about this medical ailment; everything else being equal. Thus, you have stronger moral reasons to attend to victims of an accident you have caused then from an accident that has been caused by natural factors beyond your control (a hurricane or an earthquake).

Analogously, one can argue that any global institutional order whose agents are materially involved in sustaining it have stronger moral reasons to prioritize the mitigation of the medical harm substantially caused by that institutional order. This argument is used in environmental discourses to argue in favor of a social justice, in particular "environmental (in) justice," toward the global poor who pay the price in terms of poor health outcomes due to degraded environments caused by the rich and industrialized countries (Dryzek, 2005). Therefore, if it can be shown that war, like poverty or global environmental damage, is caused by a global institutional order, then the latter has a stronger moral claim to assist in the war-related costs (all costs included) it participates in causing. Like in the discourse on poverty, war-related psychiatric cost "reparations" are not a matter of charity but of reparative justice and moral responsibility.

Let me introduce the second argument before pursuing further. When environmental problems were essentially domestic, like polluted cities or drinking water, they were largely a matter of domestic concerns. But environmental problems have now become global (like climate warming and ozone degradation), that is, they have become a shared

concern and shared responsibility. Therefore, the problems created cannot be solved anymore by isolated actions of individual nations (Goodin, 1995). Analogously, wars are likewise the responsibility of the international community—for reasons that will be shortly discussed—and therefore, can not be solved by isolated actions. War-related public health concerns, in particular, should be tackled from the perspective of a global shared responsibility because of the broad public health catastrophic consequences they engender. In the global world we live in today, shared responsibility should be "foundational" and not derived from treaty commitment alone (Goodin, 1995). This makes the idea of "shared responsibility" independent of state actions and beyond "state sovereignty"—that is, it engages the international community and a global forum that could make a much relevant difference to the outcome (Goodin, 1995). As it is wrong to think of resolving global environmental concerns in the confines of "state sovereignty" discourses, it is similarly wrong to think of war-related consequences in those terms, specifically in terms of the traditional dichotomy between a well-defined aggressor and victim that the "just-war doctrine" compels us to believe in (Walzer, 1977).

I will now provide some of the reasons why wars should be regarded as involving the international and global order and thus why wars should be regarded as a "global" rather than "local" or domestic object of concern. Clearly, there is a direct responsibility of the aggressor for having started the war; aggression is after all the work of local political leaders. Any government or leader is accountable for all political decisions taken on behalf of the people they allegedly represent; be it under democratic or autocratic regimes. Yet even if political leaders are to be blamed, war-related psychiatric costs depend on other factors. They directly depend on the extent, degree, and type of violence and trauma invested in war. But they also depend on the socioeconomic status of the affected population; poverty and socioeconomic deprivation, a common factor in war-torn societies, have been shown to be crucially linked to contributing to the prevalence of mental health disorders (Patel, 2001).

Let us tackle more thoroughly the issue of poverty. Some disagree that the world we live in is "fundamentally unjust"—in terms of the unequal distribution of wealth among nations/people. They rather argue that the world is "incompletely just" because the poor today are much better off than a few hundred years ago (Risse, 2005). However, this argument conceals the issue of moral responsibility in bringing about or creating a certain outcome, such as poverty or say a "medical disadvantage," because of some factors like war that hinder development. Second, the world we live in is unjust for many concrete historical reasons—colonialism and slavery are only a few obvious examples.

In fact, Pogge (2006) argues that poverty is itself caused and maintained by a global institutionalized order, including international and supranational organizations. He cites three global factors that contribute to poverty, namely the international resource, borrowing treaty, and arms privileges. He also rejects "explanatory nationalism," the idea that poverty, a country's predicament, and other forms of human misery and deprivation are exclusively due to domestic factors. First, the "corrupt elite" is often financially sustained through international bribery and is sometimes backed up by external rapport de force between world powers. Although there is now an antibribery convention (Organization for Economic Cooperation and Development convention; www.oecd.org/document/21/0,3343,en_2649_34859_2017813_1_1_1_1,00.html), it is not adequately enforced (Heimann & Dell, 2007). Moreover, the corrupt elite is

> [I]nternationally recognized as entitled to sell the country's resources and to dispose of the proceeds of such sales, to borrow in the country's name and thereby to impose debt service obligations upon it, to sign treaties on the country's behalf and thus to bind its present and future population and to use state revenues to buy the means of internal repression. (Thomas Pogge, 2006, p. 220)

And this is possible because of the present global order, which has not yet enshrined into international law the "doctrine of odious debt" (Thomas Pogge, 2006). In sum, poverty is sustained by a global institutionalized order. But we also established that it plays a significant role in mental health outcomes, that it is a major factor in war-torn countries, and that poverty and mental disorders impede efforts to achieve development.

All this clearly shows that war, psychiatric costs/outcomes, and poverty are interlinked and that they should be taken together when assessing war outcomes as well as the future plans and prospects of affected populations. Still, that does no justify why wars are of a global concern and a shared responsibility. I will now argue that war, like poverty, is likewise inextricably linked to a global institutionalized order besides the fact that poverty may in some cases be the primary reason behind wars particularly civil wars (Malone & Berdal, 2000). First, we live in an increasingly global and interconnected world whereby the decision to wage and/or end a war is, more often than not, an international issue even if, or when, the *casus belli* originates domestically. The interference of state interests in wars is not uncommon in world politics. On the contrary, it is usually the rule rather than the exception. In fact, many view contemporary wars as a complex socioeconomic phenomenon transcending the traditional Manichean battle between Good and Evil (Kaldor, Kostovicova, & Said, 2006). Many wars have indeed been fought for geopolitical reasons. A frequently cited example is the invasion of Iraq by American and coalition forces which is viewed by some political scientists and economists as an oil-led and oil-motivated war (McQuaig, 2004). Darfur is another example. The economic

trade between Sudan and China—Sudan's largest trading partner and the main foreign investor in Sudan's oil industry—is thought to have hindered the genocide that was taking place by sustaining albeit "indirectly" a corrupt regime (Anonymous, 2003). Indeed many countries, particularly in Africa and the Middle East, still suffer today from wars that are the result of a long-standing history of colonialism. And historical contingencies, like geopolitical and economic ones, can not and should not be discounted. Finally, there is today a widespread sense of belonging to a "global civil society" (Anheier, Kaldor, & Glasius, 2006; Kaldor, 2003) whose mission is not only to neutrally or "apolitically" fill the gap left during or after a war, but above all to actively participate in building sustainable post-war societies based on the premise that wars are a global enterprise. Failing to recognize the international implication not only in poverty but also in wars and viewing the world as a conglomeration of isolated, self-sustained, and disconnected islands, as dogmatized by the advocates of "explanatory nationalism," contribute to corruption sustenance and the perpetuation of inequality. In addition, it puts the global order as designed with its free bargaining among states/people "almost entirely beyond moral assessment" (Pogge, 2006). That is precisely why Pogge asserts that "explanatory nationalism" is a dangerous dogma indeed "the most harmful dogma ever conceived."

Furthermore, even if the responsibility solely falls on the political leaders of the aggressor party, does it justify harming the civilians on the "unjust" side of the war on the assumption that politics is a "collective responsibility?" No, for at least two reasons. First, noncombatants are supposedly granted immunity in war. Second, according to the so-called "doctrine of the double effect" targeting intentionally civilians would amount to "terror bombing" (Walzer, 1977). And only "target bombing" is commonly acknowledged to be "permissible" because the death of civilians is "foreseen" but "unintended" (Walzer, 1977). Yet as noted earlier, the highest casualties in wars are invariably among civilians. "Collateral damage" is thus as important, if not more important, than direct damage owing to its costly long-term sequels. Hence, the discussion around "intentions" loses its significance when you know that doing a certain action will invariably produce extensive damage regardless if it was intended or not. As mentioned earlier, the considerable impact of collateral damage might be explained by the fact that it is very hard to minimize collateral damage in modern warfare in view of the great damage it is consistently associated with. Therefore, from a purely consequential perspective and from a pragmatic standpoint, what matters in the end is the magnitude of casualties and the extent of damage caused in the civilian and vulnerable population.

Still others blame the people of the aggressor country for being responsible for the leaders that represent them. This is the rationale behind paying reparations in forms of taxes to the victims of the victor state. Waltzer (1977) for instance argues that this distribution of costs is not a form of collective punishment or a distribution of guilt but a consequence or sign of a "shared responsibility of citizenship." However the idea of "collective responsibility" arguably applies to regimes where good governance is already in practice. But most wars since the end of World War II have been waged in undemocratic or fairly democratic countries otherwise known as *fragile democracies* ravaged by years of violence, bloody civil wars, and political unrest. Adding these additional costs in form of taxation would worsen the problem and perpetuate the vicious circle of violence, poverty, a poor overall quality of life, and poor sustainability of a "healthy" milieu were "human flourishing" is possible or even conceivable. In fact, some argue that it was the harsh war settlement with the Treaty of Versailles at the end of World War I that created hatred and economic distress and facilitated the rise of Hitler (Orend, 2006). This is precisely why Orend contends that a post-war poll-tax on civilians is impermissible and that financial compensation can only be mandated from the personal wealth of the political and military leaders of the aggressor side. Nevertheless, it should be said that many countries involved in World War II, including Germany, Italy, and Japan ended up paying reparations (Cohen, 1968). In any case, what is certainly impermissible is to deplete the vital resources of the defeated party because, first of all, the affected civilians might not be responsible for the decisions that were taken on their behalf but most importantly because these vital resources are needed to rebuild a viable post-war "minimally just state."

For all these reasons and according to the two arguments formulated at the beginning of the section, war-related psychiatric costs can be said to be substantially caused by an institutionalized order or the failure of that global order to avoid such an enterprise we call war. Thus, not only is there a stronger moral weight for the international community and all parties involved to mitigate war-related psychiatric costs but also a "shared responsibility" to assist in remedying these war-related psychiatric conditions.

Social Capital, Mental Capital, and the Minimally Just State

"Social capital" commonly refers to the level of civic participation, social networks, and level of trust in a particular society or community that can improve its efficiency, productivity, and sustainability (McKenzie & Harpham, 2006; Putnam, 1996). The concept has been used by some researchers to demonstrate a link between the effect the structure of society has on the psychological health of populations in general (McKenzie & Harpham, 2006). Durkheim is often cited as having pioneered the idea of how social structure impinges on mental health. He asserted that suicide rates decrease in wartime because of increased social and political cohesion. His work on suicide (Durkheim, 1930) is often

cited as evidence that modern life disrupts social cohesion resulting in increased morbidity and mortality (Kushner & Sterk, 2005). "Mental capital" on the other hand refers to

> [B]oth cognitive and emotional resources. It includes people's cognitive ability; their flexibility and efficiency at learning; and their 'emotional intelligence', or social skills and resilience in the face of stress. [It] therefore captures a key dimension of the elements that establish how well an individual is able to contribute to society and to experience a high quality of life. (Beddington et al., 2008, p. 1057)

These notions are introduced for two reasons. First, social capital has been shown to be intimately related to the psychological health of societies and communities though the link is complex and multidirectional (McKenzie & Harpham, 2006; McKenzie, Whitley, & Weich, 2002). What is important here is the use of these forms of capitals as a reflection of the macro-health and wealth of nations in contrast to the micro or individual level. What is also important is the reciprocal relationship of these two forms of capitals; social capital impacts on mental health and vice versa, the latter affects these features of social life that "enable participants to act together more effectively to pursue shared objectives" (Putnam, 1996). The intricate link between cognitive/mental and structural/social capital challenges the argument of "separate spheres" in public health promulgated by some philosophers (Brock, 2005; Kamm, 1993). Mental health is an exemplar of how closely linked and interlinked are the different spheres implicated in the overall well-being and "quality of life" of populations. As already stated, mental health is multifaceted, related to both biological and also nonhealth factors such as socioeconomic and political factors (status of human rights, socioeconomic development and growth, political stability, and so forth). Failing to account for all these diverse dimensions related to mental health, including the "nonhealth costs and benefits," could be detrimental to the overall capacity to achieve an acceptable quality of life be it on the micro (individual) or macro (societal) dimensions.

The justification for individual rights do not exclusively rests on the idea of autonomy, agency, and individual well-being but also on the benefits these rights convey to society at large (Green, 2000). On the one hand, there is economic evidence of the benefits mental health investment and service development ultimately have on the individual and society (WHO, 2006). On the other hand, different public measures and interventions are implemented to promote the well-being of the society at large. Today there is even a call for countries to capitalize on their citizens' "mental well-being" if they are to prosper both economically and socially as the United Kingdom Government Office for Science recently announced in its Foresight Project on "Mental Capital and Well-being" (Anonymous, 2008; Beddington et al., 2008).

Take for example the antitobacco campaign to ban smoking in public spaces. From a cost–benefit approach banning smoking has been correlated with substantial decrease in morbidity and mortality (Eisner, 2006). But not only is the antitobacco policy a "preventive measure," it is believed to also promote a healthier collective lifestyle that could in the long run substantially decrease other types of morbidities. Similarly, one can argue that promoting post-war mental health by investing in mental health care services have beneficial effects on the ultimate "common good"—the well-being, health, and wealth of affected populations. If there is today enough evidence for nations to invest in the "mental wealth" of their population (Anonymous, 2008; Beddington et al., 2008), the need is logically even greater for war-torn societies.

It should be noted however that Durkheim's suicide theory from which the notion of "social capital" is drawn has been questioned despite the many cross-national time series studies that do support it. Suffice to mention some of them, the complexity and variability of suicide rates (Tubergen & Ultee, 2006), the lack of a clear-cut causality (McKenzie & Harpham, 2006), and an overreliance on Durkheim's suicide typology (Kushner & Sterk, 2005). Notwithstanding these limitations, social capital has been increasingly shown to play an important role in a population's mental health particularly in war-torn contexts. The equivalent of a state of *anomia* (to borrow Durkheim and Guyau's term) or lawlessness is what public health experts refer to as "complex-emergency situations" abbreviated as CES (Toole & Waldman, 1997).

Although wars generally foster social cohesion (Durkheim, 1930), the pattern in modern and recent conflicts has been the opposite with tremendous disruptions to the fabric of society associated with increased mortality and morbidity among civilians. CES captures that state of social network disruption and disintegration amid a collapse of political, social, economic, and health care infrastructure in which are trapped vulnerable civilian populations (Mollica et al., 2004). It was shown that the disruption of "social capital" is a nidus for further violence and aggression. Moreover, the destruction of life-sustaining infrastructures and economic deprivation, separation anxiety, and others forms of traumas, violence, and humiliating conditions—witnessed or experienced—have demonstrable effects on morbidity and mortality. Children in particular suffer the most in these disrupted settings from the experience they witness rather than from direct violence (Barbara, 2000). Another aspect of *anomia* is related to what mental heath workers call "individual disintegration" or destruction of the autonomous self as a consequence of torture and political repression. Hence, there are two intertwined levels of *anomia*, a macroscale destruction of a society's cohesiveness and a microscale destruction of the individual psychological self.

Rebuilding social capital is not only indispensable for reconciliation but it also provides a framework for recovery

and socioeconomic development. Indeed social capital seems to be the missing link between poverty and mental health (McKenzie & Harpham, 2006). Poverty impedes productivity, which is a burden on the family, which leads to increase health costs, which leads to poverty. The vicious circle connecting mental health disorders, poverty, and social capital seems to be inextricably linked. This is another example how an apparently "nonhealth related" cost such as restoring and investing in social capital may have ultimately a positive impact on the overall population's mental well-being, indeed its "mental capital."

Having established now what social capital amounts to and its link to mental health, I contend that investment in post-war mental health is not only important to restoring the disrupted social fabric of society but necessary for a sustainable minimally just state (MJS). It is only recently that *jus post-bellum* or the norms of justice after war have been receiving the prominence it deserves. Orend (2006) argues that there is a necessity to explicitly formulate a list of issues that must be settled after a war. There are conceptual and historical reasons as to why an exhaustive *jus post-bellum* ought to be formulated, but the most obvious reason is that a badly wrapped up war has been historically a seed for future violence and bloodshed (Orend, 2006).

An MJS is a legitimate community in a post-war reconstruction phase that has the duty to act reasonably, responsibly, and justly to secure individual basic rights such as "security, subsistence, liberty, equality and recognition" (Orend, 2006). Therefore, the degree of sanctions, punishment, and compensations should not compromise the viability and sustainability of the MJS. For example, draconian economic sanctions are impermissible if they would exhaust the vital resources left for the legitimate MJS to rebuild the fragmented society and "state" and hence compromise efforts of recovery. However, the current account of the MJS is incomplete. The "post-war rehabilitation" or *jus post-bellum* list fails to account for the shattered social and mental capital. The list of "primary goods" the MJS is supposed to guarantee only includes political, military, economic, legal, and apologetic reparations (Bass, 2004; Orend, 2006) excluding any health-related costs. But for all the reasons already discussed, there is a positive obligation to ensure mental and physical well-being. Failure to take into account the vast psychosocial damage will probably hinder recovery efforts and could push the nation in a socioeconomic and political downhill (Danieli, 1998). It follows that an MJS will be hardly viable if it fails to invest in the social and mental capital of its affected civilian population.

"Psychiatric Imperialism" and Other Controversies

Despite the strong moral claims advanced so far, many objections could be raised. Some have argued against

prioritizing post-war trauma programs which is viewed as a form of "psychiatric imperialism" (Bracken & Petty, 1998; Summerfield, 1998, 2000).The proponents of that view argue along three lines. First, PTSD does not adequately apply to non-Western populations because of cultural differences. They argue that the current discourse on trauma is based on three wrong assumptions: a strongly individualistic approach to life, psychiatric universalism, and the relevance of Western forms of psychotherapies to other cultures. The second line of argument is that the universal application of PTSD to any population regardless of its particularities may generate large inflation of people in need of treatment (the so-called "medicalization" argument). Third, because PTSD is viewed as "epiphenomenal," trauma counseling (e.g., psychotherapy as applied in the West) is not only irrelevant but above all a "distraction" that fails to capture the most pressing needs and priorities of traumatized populations.

However, acknowledging that cultural differences do exist is insufficient to argue against exporting mental health resources, knowledges, and forms of expertise and is not enough to deny PTSD's "universalism," at least in the sense of its common prevalence in war-torn societies. What is certainly wrong is designing post-war policies that ignore the sociocultural context and other particularities of a traumatized society; such as different perspectives and approaches to trauma, violence, suffering, and healing. What is also wrong is the view that war-related psychological and mental disorders are a problem inside "individual minds" (Bracken, 1998). This claim or belief that the brain is the "obligatory" passage point of all ailments—social, political, economic, and so on, has become a common tenet in our epoch (Rose, 2007). On that point, I strongly agree with Bracken, Summerfield, and others that the current neurobiological trauma discourse that views society as an ensemble of individual brains in need of treatment is not only simplistic but most importantly misleading as it fails to capture the problem at stake.

Second, and as noted earlier comorbid with PTSD are other serious and disabling mental health disorders that are risk factors for diverse health problems. Failing to intervene early and treat those war-related mental disorders could compromise the health prospect of the individual and overall quality of life of the traumatized population—let aside the additional heavy economic burden that comes along and falls on the individual before the society at large. In addition, one could argue that PTSD's prevalence today is likely due to the destructive nature of modern warfare rather than merely the result of "medicalization." Furthermore, although still scarce and sometimes controversial, there is increasing evidence that there are common neurobiological pathways underlying stress and trauma-related psychopathologies (Newport & Nemeroff, 2000). In any case, what concerns me in this specific article is the pragmatic approach to such public health and policy problems, not the "constructivist" approaches that question the reality of PTSD and the limits of the

neuroscientific discourse. Such questions are important and should be further investigated.

Some still do not deny the reality of PTSD, which is seen as empirically confirmed but rather question the "timelessness" of the concept, "the origins of this reality and its universality" (Young, 1995). It is important to keep in mind that PTSD as a psychiatric category was only introduced in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) published in 1980. Prior to that, trauma and traumatic memories were present in different forms and appellations since the 19th century; "war neuroses," "shell shock," "railway spine," "nervous shock," "gross stress reaction," and so forth (Young, 1995). However, it could be argued that medical concepts, diseases, and disorders are de facto contingent for the simple reason that biomedical "realities"—and arguably other scientific narratives likewise—are attuned to the available evidence and progress bound to the state of knowledge and technical advances of particular historical epochs. Accordingly, that PTSD has been "recently discovered" or indeed "invented" is not a good reason to make it an "epiphenomenon".

It could also be said that even if the incidence of PTSD in postconflict populations may have been conflated, this kind of critique may actually undercut the much needed mental health programs for vulnerable populations as some have already attested (Silove et al., 2001). Investment in mental capital and resources, in other words investment in the overall well-being of present and future generations, has been shown to be worthwhile particularly because of the its vast socioeconomic and political bearings, frequently ignored by policy makers and researchers (Anonymous, 2008; WHO, 2003). As some have argued (Njenga, Nguithi, & Kang'ethe, 2006) war-related mental health consequences have been shown to significantly contribute in setting back Africa, for instance, from achieving the "Millennium Development Goals." Hence, denying the exportation of such forms of expertise and treatment on the basis of other priorities could be detrimental. Of course, this does not mean that war-related psychiatric costs are the only culprits in setting back Africa. Needless to reiterate, that socioeconomic and political factors are fundamental for the possible and successful (re)construction of any society.

Another recurrent criticism questions the reality of all psychopathologies. One of its major proponents, the antipsychiatry movement of the 1960s, views mental illness as a "myth" (Szasz, 1961). However, such a line of reasoning is irrelevant for this specific article because its basic premise is that psychiatric conditions *do* exist. To be sure, acknowledging their reality does not necessarily mean approving uncritically of what Michel Foucault (1972) calls their "grids of specification." Classificatory systems such as the *DSM* do have failings and inadequacies. In fact, the *DSM* has been criticized over the years, and since its publication, on many grounds: for

lacking reliability and validity (Kendell & Jablensky, 2003; Regier et al., 1998), for failing to fully account for the genesis of psychopathologies—in terms of causes and explanation of their emergence rather than merely being a checklist of symptoms (McHugh, 2005), for shifting the borders of "normalcy" and "abnormalcy" (Rose, 2007), for "medicalizing" lifestyles and gender inclinations (Drescher & Karasic, 2006; Spitzer, 1981), or even for being nothing more than a coup carried out by a handful conspirators—in reference to Spitzer and his select group which drafted the third version of the *DSM* (Young, 1995). However it is impossible to discuss in detail the shortcomings of the current psychiatric nosology given the scope of this article. Such a criticism is much needed and should definitely be further expanded.

Conclusion

This article launched a normative debate on the role of mental well-being in post-war reconstruction phases, a crucial yet ignored problem at the heart of political discourse, more specifically the so-called "just-war" doctrine. I introduced a new ethical framework, "an ethics of post-war mental health" in line with what Paul Ricoeur has termed an *ethics of memory* (Ricoeur, 1999), which adds to the conventional debate around (mental) health that is usually centered around one of the following frameworks: Kantianism, egalitarianism, and human rights approaches.

I started with the following problematic: Governments have a positive obligation to guarantee mental health care at the same level of any other physical illness. However, war-torn countries fail to fulfill this positive obligation. This was the motivation to explore and argue that post-war mental health investment is not a matter of charity and that there is a strong moral claim to invest in it. Two main arguments were formulated in favor of that claim, namely, that harm is invariably done and that there is a shared responsibility to avoid that harm and thus to mitigate the psychiatric and psychological ailments brought about. The arguments were drawn on Pogge's (2004) "relational conceptions of justice" and contemporary discourses in "environmental justice" (Dryzek, 2005; Goodin, 1995). I thus contended that war, similar to poverty or global environmental damage, is a global concern and ought to be tackled in terms of shared responsibility. This implies building in the post-war phase a viable and sustainable MJS which is another way to say, restoring the so-called fragmented "social capital" of the affected population. And because the latter is linked to mental health outcomes—albeit admittedly in a complex way, I argued that investing in post-war mental health which ultimately impacts on social capital should be dealt with, not as a "separate sphere" but as part and parcel of the post-war discourse on restoring justice.

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