Themes in *International Psychiatry*

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In this, the inaugural issue of *International Psychiatry*, we are highlighting the first of many themes that are of interest and concern to psychiatrists around the globe. Terrorism is both directly and indirectly the predominant topic in our media at present. What impact does living with such a threat, an 'ever-present danger', have on our mental health? Even if we are not directly affected by terrorism, psychiatrists cannot ignore the effects such incidents have had on societies in both the developed and the developing world.

We have commissioned a series of articles which report how different aspects of the terrorist threat have influenced the lives of people around the world. Four articles appear in this issue and a further set will follow in the second issue of *International Psychiatry*.

Herman and Susser discuss the effects of the events of 11 September 2001 on people living in Manhattan and make recommendations about how psychiatric services should respond in such circumstances. They emphasise the need for advance planning.

Njenga and colleagues discuss the traumatic events in Nairobi, Kenya, in 1998, when a huge bomb destroyed the American embassy. Many Africans suffer severe trauma more frequently than citizens in the United States, but their psychiatric services are far less well equipped to deal with the sequelae of such events. It is arguably a responsibility of psychiatrists in the developed world to assist in mental health promotion within developing societies. We learn about the Mental Health Policy Support Project, which is co-sponsored by the WHO and the UK Department for International Development; the hope is that the Kenyan model will be replicated in other countries.

De Jong, Komproe and Van Ommeren challenge psychiatrists to consider what is an appropriate professional role in response to terrorist-inspired events. In a controversial article, they argue that it is the responsibility (and indeed the nature) of a culture to respond with a network of supportive structures and rituals. This is exactly what happened in Kenya – a recourse to prayer and support from the family. We need to consider, though, whether this is enough. Njenga and colleagues think not. On the other hand, are we, in the Western world, in danger of going too far in the direction of 'pathologising' experience, to the extent that professional support will be sought after exposure to traumas that are a lot less dramatic than 11 September? And if so, does it matter?

Finally, in a thought-provoking reflection on events in Northern Ireland, Lord Alderdice discusses the way in which a society that has lived with 'Troubles' for many years adjusted to chronic threat. Despite the persistent danger, there is no evidence that this translated into heightened vulnerability to mental ill-health.

Our readers will understand that the views of the authors expressed in these articles are not the views of the Royal College; nor are they necessarily the views of the editors of this novel bulletin. Enjoy and reflect. We hope you will appreciate them as much as we did.

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The World Trade Center attack: mental health needs and treatment implications

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On 11 September 2001, the United States suffered the worst terrorist attacks in its history. In New York City, approximately 3000 persons were killed at the World Trade Center, while many thousands fled for their lives. Millions of other city residents observed the burning towers and breathed the acrid smoke that blanketed the city. Compounding the massive physical destruction and loss of life, the psychological impact of these terrifying events on the populace was profound – there were significant increases in mental distress and symptoms of disorder.

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Prevalence of disorder

In a rapid needs assessment commissioned by local government in the immediate aftermath of the attacks, we estimated a minimum of half a million cases of diagnosable mental disorder in the New York region consequent to 11 September (Herman *et al*, 2002; Susser *et al*, 2002). Subsequently published research confirmed the massive emotional impact. A telephone survey of 1008 adult residents covering much of Manhattan (the borough of New York City in which the World Trade Center was located) found that 7.5% had probable post-traumatic stress disorder (PTSD) related to the attacks roughly one to two months after 11 September (Galea *et al*, 2002*a*). A web-based national survey conducted at approximately the same time estimated similar rates of probable PTSD among New Yorkers (Schlenger *et al*, 2002), while a third survey, by Hoven *et al* (2002), of approximately 8000 New York City schoolchildren in grades 4–12, found that 10.5% had PTSD related to 11 September. The Hoven study, and those by Galea's team, also documented increases in other disorders, including depression and agoraphobia. Beyond the development of diagnosable mental disorders, there was also evidence of a dramatic increase in sub-threshold psychological distress in adults and children across the United States following the attacks (Schuster *et al*, 2001).

Risk factors

As seen in the research on the Oklahoma City bombing of April 1995 (North *et al*, 1999; Sprang, 1999), the risk of developing mental disorder following a terror attack appears to be associated with the degree of exposure to the event. For instance, rates of depression were higher among adults who reported that a friend or relative was killed or who had lost their job as a result of the attack on New York (Galea *et al*, 2002*a*). Although systematic data have yet to be reported on rates of PTSD among persons who survived the evacuation of the World Trade Center and the surrounding buildings, there is evidence that being in one of these buildings during the attacks was associated with the development of symptoms of PTSD (Schlenger *et al*, 2002). Since the attack received an unprecedented degree of exceptionally graphic media coverage, including live television broadcasts of the airplanes' impact, victims falling to their deaths and people fleeing for their lives, some have wondered whether indirect exposure may also have increased the risk of subsequent disorder among viewers. While the direction of causality remains unclear, there appears to be evidence of an association between frequent viewing of these images and symptoms of disorder (Schlenger *et al*, 2002).

A previous body of research has documented the role of a variety of non-exposure-related risk factors on the psychological sequelae of disaster. Risk factors for adverse outcomes include both individual attributes (e.g. female gender, pre-existing psychiatric symptoms, history of exposure to trauma) and social factors (e.g. low levels of social support) (Norris, 2001). In the data reported so far in the aftermath of the attacks of 11 September, such factors associated with the development of PTSD include job loss, female sex, low social support and more life stressors experienced in the preceding 12 months (Schlenger *et al*, 2002; Galea *et al*, 2002*b*).

Time course

The ultimate course of these disorders remains to be seen. Regarding PTSD per se, short-term follow-up data suggest that the majority of cases may have resolved fairly rapidly; the reported rate of current PTSD related to 11 September in Manhattan had declined to 1.7% by January 2002, and rates of depression had also decreased significantly (Galea *et al*, 2002*c*). These declining rates are consistent with some but not all previous studies of PTSD (Kessler *et al*, 1995; North *et al*, 1999). None the less, the absolute number of persons experiencing ongoing PTSD resulting from the attacks several months afterwards still exceeded 100 000, while there may still be delayed-onset cases that have yet to manifest.

Service provision

Thus, the attacks of 11 September had a profound effect on the mental health of New Yorkers. What are the implications of these findings for psychiatrists and other mental health providers who may be called upon to respond to community needs following a major terror attack? In the aftermath of such an event, the requisite mental health service response can be expected to unfold in acute and post-acute phases. The duration of these phases is dictated by the intensity of the disaster, the degree of ongoing threat and the response of the community.

Acute phase

Services needed during the acute phase include crisis intervention, psycho-education, and social support to help people cope with psychological distress caused by exposure to the disaster. Much of this work is delivered '*in vivo*' – in schools, places of worship, and other emergency recovery settings, rather than formal mental health settings. In general, communities (including New York) have been inadequately prepared to mobilise resources in the immediate wake of mass disaster, and this has greatly limited their capacity to deliver interventions effectively. Although it is hoped that these early intervention efforts, in addition to their immediate palliative effects, will also confer ongoing benefits, there is scant empirical evidence of their long-term impact (National Institute of Mental Health, 2002). In particular, a recent review of studies of psychological 'debriefing' (the most commonly studied model) concluded that it is ineffective in reducing the risk of subsequent PTSD and other disorders (Suzanna *et al*, 2001).

Post-acute phase

After the acute phase, the focus largely shifts to the treatment of diagnosable mental disorders, to persons whose symptoms have not resolved and to those who have

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experienced delayed onset of such disorders. Fortunately, there is a somewhat more well established research literature regarding effective treatments for mental disorders most likely to result from exposure to mass violence and severe trauma (National Institute of Mental Health, 2002). A number of studies support the efficacy of cognitive–behavioural psychotherapeutic interventions for PTSD, while there is also some empirical support for group and individual psychodynamic therapy. Pharmacotherapy may also provide benefit for people experiencing PTSD, as dysregulation of numerous psychobiological systems is often associated with it. In addition, the high frequency of co-occurring psychiatric disorders among people with PTSD underscores the importance of considering pharmacotherapy in the treatment of PTSD (Foa & International Society for Traumatic Stress Studies, 2000).

Activities that focus on bringing together members of the community to provide social and emotional support for persons who have suffered significant losses enhance social cohesion and mutual support, which, in turn, have important health and mental health benefits.

Community response

Although the treatments described above are focused on individuals, families and small groups, the need to target interventions at the broader community level should not be overlooked. Activities that focus on bringing together members of the community to provide social and emotional support for persons who have suffered significant losses enhance social cohesion and mutual support, which, in turn, have important health and mental health benefits. As exemplified by New York Mayor Rudolph Giuliani's leadership in the days following 11 September, community resilience is also greatly enhanced by government leaders who can effectively promote a sense of common purpose and optimism even in the face of enormous tragedy.

Finally, it is essential to have an infrastructure in place beforehand if effective mental health interventions are to be delivered following large-scale terrorist events. This includes comprehensive planning for a coordinated response, a well-trained workforce, and greater recognition on the part of government authorities that attending to mental health concerns is a crucial component of public health preparedness in a time of terror.

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THEMATIC PAPER – TERRORISM

Africa: the traumatised continent, a continent with hope

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Many African countries gained political independence in the 1960s and 1970s and went through difficult times in economic, political and security terms in the 1980s and early 1990s. Mental health services and research were not spared and stagnated or deteriorated during this period. The effects of poor governance, inequitable distribution of resources and environmental degradation conspired with natural and man-made disasters (wars in particular) to drive Africa into an abyss of despair.

In East, West, Central and Southern Africa, there is presently fighting over issues that seem unclear even to the combatants. Conflicts, including wars and civil strife,

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