

Terrorism, human-made and natural disasters as a professional and ethical challenge to psychiatry

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The consequences of terrorism, wars and natural disasters are a challenge to the psychiatric profession. The large numbers of people estimated to have mental health problems surpass the capacities of existing mental health services, whether modern or traditional. The bulk of the 35 million refugees and internally displaced people worldwide reside in countries that, on average, have less than one psychiatrist or psychologist per 100 000 people (WHO, 2001). Even the 500 000 people estimated to need some form of psychological support after the attack in New York on 11 September 2001 exceeded the service capacity, despite the fact that New York has the highest density of mental health professionals in the world (Herman & Susser, this issue, pp. 2–4). Elsewhere, many survivors of various types of disaster reside in peripheral areas of countries and are not covered by modern mental health services.

Services for survivors

Survivors often belong to a different ethnic or socio-economic group from those who seek to offer help. They express their plight in a specific discourse and use a variety of explanatory models. Modern mental health services, even if they are community oriented, tend to exclude specific groups. There are several reasons for this:

- many mental health professionals are not adequately trained to deal with certain types of people
- many survivors are stigmatised (especially rape survivors)
- many survivors are too poor to pay for services or too afraid to travel to access services
- many survivors do not trust or understand the rationale of modern psychosocial or mental health support.

Traditional services offer support to survivors but do not always break through social stigmas, can be expensive and are of varying effectiveness. Collaboration between allopathic and traditional services is often advocated but is also a challenge (Hiegel, 1996; de Jong, 2001).

A further challenge to psychiatry is that most conflicts are the result of political, economic and sociocultural processes, and the sequelae of such conflicts can likely be resolved only by multilevel, multisectoral public health approaches informed by social sciences (especially medical anthropology), behavioural sciences and epidemiology.

Most protracted conflicts are related to competition for power and resources, and result in predatory social formations; they affect large, displaced and mostly poor populations and they are often accompanied by cycles of violence (Hamburg *et al*, 1999). Conflicts that are protracted require flexible but sustainable solutions, both functionally and geographically, and may require that paraprofessionals from among the survivors move to other areas together with the displaced persons when the armed conflict dictates a continuation of their journey. Public mental health activities in such regions must thus accomplish more than the training of helpers.

Frameworks are necessary for setting up mental health systems in diverse circumstances. An example of such a framework is the organisation of mental health care within primary care (de Jong, 1996; WHO, 2001). Survivors of extreme stressors such as war, genocide, persecution, political repression, torture, ethnic cleansing or terrorism in developing countries are prone to a range of additional vulnerability factors, such as increased economic hardship, lack of skills fitting the new environment, marginalisation, discrimination, acculturation, poor physical conditions and a collapse of social networks (de Jong, 2002). Most mental health problems of survivors in these contexts are not likely to have been solely determined by traumatic events but also by changes in the social context. As a result, both psychological and social interventions have a role.

The overextension of Western categories

Mental health professionals are increasingly trained to orient their interventions and service delivery models towards evidence-based practice. Research in post-conflict situations has gravitated towards the epidemiology and treatment of post-traumatic stress disorder (PTSD). Yet the study of this Western diagnostic category in non-Western contexts may lead to its reification without evidence that this category is the most relevant of possible descriptions of local survivors' mental health problems (Marsella *et al*, 1996; Shrestha *et al*, 1998). This is resulting in selective attention to PTSD in many intervention programmes at the expense of other types of mental health problems. For example, we studied psychopathology in post-conflict Algeria, Cambodia, Ethiopia and Gaza. As expected, we found a 3- to 10-fold increase in

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PTSD among those who had been exposed to violence. However, we also found a 1.2- to 6-fold increase in mood disorder and non-PTSD anxiety disorder (de Jong *et al*, 2003). Moreover, we found that disability was more associated with mood disorder and anxiety disorder than with PTSD. This calls for a paradigm shift among professionals who focus more or less solely on PTSD within trauma rehabilitation programmes.

Another challenge is the sole use of prevalence rates to estimate need for treatment. A recent study showed that US prevalence figures for psychiatric disorders decreased by 17–32% after adjustments were made for help-seeking, life interference and use of medication (Narrow *et al*, 2002).

With respect to psychotherapeutic research, we suffer from a 'redundancy fallacy': research funds tend to gravitate to prove what is proven. The consequence of this is that, in the West, most funds are spent on research into cognitive-behavioural approaches. We doubt, however, whether it is appropriate to use this approach with survivors worldwide. Even if the evidence on cognitive therapies can be generalised, such therapies are not easily learned. Given the absence of mental health professionals outside the West (WHO, 2001), it is unlikely that cognitive therapies can be made widely available in the foreseeable future. Approaches that may be implemented by paraprofessionals appear more feasible, such as problem-solving approaches (Gath & Mynors-Wallis, 1997) or group, family or individual psychosocial counselling.

A preferred direction

Within the public mental health field, criteria other than prevalence should be used to select priorities (de Jong, 2002; de Jong & Komproe, 2002). Examples of such criteria are:

- level of functioning
- perceived needs of the population
- motivations for help-seeking
- problems that may be treated with limited resources
- cost-effectiveness.

The main question is how to reformulate mental health care policy to strengthen a process of natural healing, especially after emergencies. To enable this process, a modest attitude towards the role of psychiatry is desirable: psychiatry does not have a monopoly on the healing of extreme stress. The field of community psychology, for example, has a lot of experience in strengthening coping, social support and empowerment within communities (Dalton *et al*, 2000).

Although experience in the management of the consequences of conflict is mostly from the West, the concepts of coping and social support without doubt also play a central role in non-Western contexts (Emmelkamp *et al*, 2002). Cultures develop resiliency and coping strategies in the form of mourning, healing, purification, reconciliation

and commemoration rituals (de Jong, 2002). The local community may be reinvigorated by people taking up the daily routine of work or caring for children, or through income-generating activities, rural development and micro-credit schemes. Collaboration with community development workers will advance the field. The overall approach has to fit within the public health structure. It is therefore necessary to adopt a systemic approach, to link individuals, families, communities and the society at large. The sequelae of traumatic events need to be conceptualised as consequences that manifest themselves on different levels, not merely within the individual.

Elsewhere, we have described a wide variety of preventive and curative interventions (de Jong, 2002). To find out which interventions are effective demands a large amount of creativity and courage from our profession with respect to intervention programmes, funding and research.

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