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Round Table Discussion

The best immediate therapy for acute stress is social

Derrick Silove[1]

The above paper by van Ommeren et al. is of immense importance in guiding future mental health service developments in low-income countries afflicted by conflict. As such, the article should be essential reading for leaders of international nongovernmental organizations and United Nations agencies. Although measured in its style, the arguments mobilized present a radical challenge to those single-issue advocates promoting trauma counselling programmes or short-term psychosocial projects.

I believe that some of the arguments, however, need to be considered further. One problem is that trauma advocates do not distinguish sufficiently between common, self-limiting psychological responses to violence and the persisting reactions that become complicated and disabling. My rule of thumb is that the best therapy for acute stress reactions is social: providing safety, reuniting families, creating effective systems of justice, offering opportunities for work, study and other productive roles, and re-establishing systems of meaning and cohesion — religious, political, social and cultural.

Nevertheless, there will be a small minority of persons who do continue to suffer from severe traumatic stress reactions, and that group emerges in increasing numbers over time. Services then should be accessible, inviting (people with chronic PTSD are wary of presenting themselves) and offer state-of-the-art interventions: this is difficult to ensure, because such interventions are multimodal and require substantial skills. Yet, at present, nongovernmental organizations fuelled by donor enthusiasm rush in to debrief trauma survivors *in the early phase* when such interventions are not needed and, commonly, leave just at the point when the more chronic cases emerge, the minority who really do need expert assistance! In that respect, the dictum "not too early but not too late" may serve as a useful guide to reverse the present trend.

A second problem is that we have become accustomed to epidemiological studies yielding rates of PTSD or depression of 30–40% in postconflict populations. These figures provide little guide to actual need. The rates of help-seeking behaviour for severe psychiatric disorders (including the minority with

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unremitting traumatic stress) may be more like 2–3% per year. This represents, in fact, a huge number of persons in dire need, especially if one considers the adverse multiplier effect on families and communities of caring for a person who is disabled, acting in a bizarre way or possibly violent.

In my view, therefore, two key issues confront the field from a practical point of view. The first challenge is changing entrenched perspectives and practices of international agencies and donors, so that they give priority to supporting integrated community-based mental health programmes that focus on social need arising from mental disturbance, rather than special issues or particular diagnoses.

The second consideration is whether such programmes can be undertaken entirely within primary health care systems, given the wide range of skills needed to deal with psychosis, severe mood disorders, postpartum disorders, severe anxiety disorders including the minority with disabling PTSD, organic disorders, and epilepsy and its complications, among others. Many community health services in conflict-affected countries are depleted of resources and skills and face overwhelming demands in relation to other obligations. Brief training in mental health is hazardous (and training-the-trainer programmes even more so); in this field, a little knowledge is a particularly dangerous thing.

In some resource-poor settings, therefore, there is a case for establishing, at least as a developmental step, a small, expert resource team with international input to provide supervision, training and consultation in order to ensure the promotion of skills and professionalism. As a core team develops and the initial pressures of other work lessen to some extent, skills can then be transmitted to primary care workers. ■

What exactly is emergency or disaster "mental health"?

Derek Summerfield[1]

Firstly, I must own to being one of the "vocal group of observers" mentioned in the paper by van Ommeren et al. a critic of the field that sprang up little more than 15 years ago around the idea that "post-traumatic stress" was an urgent public health matter in its own right. Indeed, "trauma" may now have displaced hunger as the first thing the Western general public thinks about when a war or other emergency is in the news.

The authors make succinct mention of some of the problems associated with the development of PTSD, but omit a key one: the largely non-Western populations targeted did not ask for interventions of this kind. As an illustration, I was recently on a professional visit to the occupied Palestinian territories, where something akin to a mental health melee has resulted from a plethora of programmes imported to deliver counselling because outsiders thought it was a good idea. Most Palestinians do not: counselling is not a culturally familiar activity, and the people use all their energy to survive in a deepening health and human rights crisis.

Many programmes of this kind have been funded under the umbrella term "psychosocial", as mentioned in the base paper. When I was a consultant to Oxfam I was against this term since in practice it had become too quickly collapsible into "psycho". When van Omerren and colleagues opt for a conceptual distinction between social and mental health interventions, they are reproducing the tradition since the Enlightenment to regard the physical confines of the human individual as the basic unit of study, and for the mind to be examined by a technical methodology akin to that applied to the body. Thus mind, or "psychology", is to be located inside the body — between the ears — whereas what is "social" is outside the body and outside the frame of reference. But it would be more realistic to see our psychology as having a root outside the body, in the way that we live, and to consider the meaning of things — in particular a sense of coherence — as arising from our practical engagement with the world. Lack of coherence is bad for people: if there is such a thing as a core fact about human response to disasters and violent upheavals, it is that survivors do well (or not) in relation to their capacity to re-establish social networks and a viable way of life. Western mental health models have always paid too little attention to the role of social agency, including work, in promoting stable well-being and mental health.

The authors' description of basic responses in the acute emergency phase seems broadly right (though "psychological first aid", like "public mental health", may be an oxymoron). In relation to the restoration of normal activities, I was pleased to see their mention of schools: the child trauma literature can sometimes give the impression that counsellors are more critical than schoolteachers.

It is right to point out that in complex disasters there will be no clear demarcation of "emergency". Indeed, we talk of the trauma of war but not the trauma of hunger. Why are the deaths of millions — yes, millions — of children every year from the diseases of poverty not an emergency, but "normal"?

In relation to advocating the training of primary health workers by "mental health specialists", whose knowledge counts? There has often been a tension in WHO material on mental health between the wish to acknowledge local worlds and the wish to promote Western mental health technology as a reproducible toolkit. How, for example, would primary health workers be trained about depression? Forecasts by WHO that within two decades depression will cause the second highest disease burden globally assume that the Western psychiatric construct is valid everywhere. This is surely to commit the same error bedevilling most of the psychiatric literature on war and refugees: it is what Kleinman called a "category fallacy" to assume that, just because similar phenomena can be identified in various settings worldwide, they mean the same thing everywhere. Even the best back-translation methodologies cannot solve the problem, as it is not one of translation between languages but of translation between worlds. We need to remember that the Western mental health discourse introduces core components of Western culture, including a theory of human nature, a definition of personhood, a sense of time and memory, and a secular source of moral authority. None of this is universal.

Consensus statements have to keep their feet on the ground, and I am pleased that this one largely does so. The note of caution seems wise, if only because the business of other people's minds is ultimately as much a matter of philosophy as of science. ■

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