

Mental Health in the Aftermath of Disasters: Consensus and Controversy

Mitchell G. Weiss, MD, PhD,* Benedetto Saraceno, MD,†
Shekhar Saxena MD, MRCPsych,† and
Mark van Ommeren, PhD†

*Department of Public Health and Epidemiology, Swiss Tropical Institute, Basel, Switzerland; and †Department of Mental Health and Substance Dependence, World Health Organization, Geneva, Switzerland.

Reprints: Shekhar Saxena, MD, Department of Mental Health and Substance Dependence, World Health Organization, Avenue Appia 20, 1211 Geneva 27, Switzerland. E-mail: saxenas@who.int

Copyright © 2003 by Lippincott Williams & Wilkins

DOI: 10.1097/01.nmd.0000087188.96516.a3

With the World Health Report 2001 (World Health Organization; WHO, 2001a) devoted to mental health, international health has never been more attentive to mental health than now. With this enhanced recognition have also come increased expectations and responsibilities, including the development of policy to mitigate the effects of natural disasters, armed conflict, war, and forced displacements. Although it is widely accepted that large disasters require a humanitarian response, decision makers need to know what kind of response is helpful to address the complex mix of needs that require attention—devastated communities, social disruptions, the emotional burden of massive fright and loss, psychiatric disorders, and disability—in countries with few mental health resources. However, expert opinion about the priorities and what should be done varies considerably (Boehnlein and Kinzie, 1992; Bracken and Petty, 1998; de Jong, 2002; Dyregrov et al., 2002; Eisenbruch, 1992; Green et al., in press; National Institute of Mental Health, 2002; Norris et al., 2002; Silove et al., 2000; Summerfield, 1999, 2000; Weine et al. 2002). Many aspects of disaster management are complex and hypothetical, and this field has been characterized as ridden with mythology (de Ville de Goyet, 2000). Conceptual clarity for mental health policy is required to address the mental health needs of populations in dire circumstances. We conducted a qualitative survey to elicit expert opinions about current approaches to mental health policy for disaster management in middle and low-income countries, where most disasters occur and where mental health resources are scarce (WHO, 2001b). Those surveyed aimed to identify a range of policy-relevant views and areas of consensus and controversy.

METHODS

We approached 46 acknowledged international experts on mental health and disaster management. All experts were contacted by e-mail or fax, and a letter was sent by post. Follow-up correspondence was sent to those who did not respond initially. A total of 17 persons (35%) responded. Out

of 17, 13 respondents (76%) lived in western, industrialized countries.

Experts were asked to answer open-ended questions about public health policy for disaster management with reference to the following topics: (a) nature of disasters for which specific mental health policy is needed, (b) goals and approaches to mental health interventions, (c) relevance of PTSD and the classification of traumatic stress responses, (d) critique of mental health policy for disaster management, including the present focus on PTSD, (e) ways by which efforts to restore the viability of communities may be attentive to local cultural values, and (f) research needs. Two out of 6 topics covered PTSD, reflecting its dominant place in the discourse on disaster mental health. A copy of the questionnaire is available upon request.

We analyzed the responses and relevant literature qualitatively, making use of the WinMax software program for prose data (WinMax, 2000). A detailed report was sent to the respondents for their review and comments. Because our aim was to identify issues and provide a qualitative account of areas of consensus and controversy and because of the low response rate, we did not identify frequencies of responses in presenting the survey findings.

RESULTS

Nature and Diversity of Disasters

Our question referred to the gamut of natural disasters and violent human conflicts and asked about the specific responses that may be required for different kinds of disasters. It was noted that each disaster poses distinctive challenges for recovery efforts. Even catastrophic events under the same heading, such as earthquakes, occur in distinctive settings and have unique features. Human conflicts involve a moral dimension and may thus require greater attention to questions of trust, social justice and retribution. Occasionally, such issues, however, can be a feature of natural disasters as well. When corruption and fraudulent building practices result in preventable material destruction, serious injury, and death, then questions of justice and retribution through social policy and litigation also arise. Overall, contrary to our expectations but consistent with the literature (e.g., Norris et al., 2002), they suggested it was unnecessary to systematically differentiate between natural and human-made disasters in formulating a broad approach to mental health policy. Some respondents, however, emphasized the importance of distinguishing enduring situations (e.g., ongoing war, ongoing drought), which may require different kinds of interventions than time-limited, acute disasters (e.g., a terrorist attack, a hurricane), because chronic disasters result in simultaneous acute and ongoing disaster-related problems. Experts also emphasized consideration of the destructiveness of the event,

rather than the type of event, to predict the extent of problems and to indicate what interventions may be needed.

PTSD and the Classification of Traumatic Stress Responses

Questions about the value, relevance, and epidemiology of PTSD were, as expected, the most controversial. Several respondents found the current formulation useful but argued that too much emphasis has been placed on this disorder to the exclusion of other relevant issues. As one respondent noted:

■ *While the concept of PTSD is useful, it has dominated the study of many disaster and emergency responses. The better epidemiological literature highlights the need for a range of diagnostic assessments. Screening should ensure that there is a recognition of risk, adaptive responses and the common patterns of psychosocial morbidity and the contribution of background factors, both experiences and strengths and vulnerabilities. Posttraumatic growth should also be considered.*

Other respondents, however, considered the concept of PTSD to be culture-bound and irrelevant to the experiences of people outside western cultures. As one respondent stated “PTSD is a western notion of some validity when we have a ‘western’ notion of self and agency. Not elsewhere.” Some argued that attaching a clinical diagnosis of a psychiatric disorder for all those who either needed or might benefit from clinical attention is stigmatizing. Some respondents also argued that frequent comorbidity reflects inappropriate over-inclusiveness and inadequate specificity.

Some respondents who were critical of the concept argued that the diagnosis of PTSD does not represent a proper disorder but should instead be considered a normal response when coping with extreme stressors—notwithstanding how distressed the disaster survivor may be. Others argued for an even broader critique, questioning whether a professional emphasis on psychiatric disorder may actually interfere with the agenda of community-based mental health programs that are concerned with a much broader spectrum of mental health problems. They argued that attention to any psychopathology apart from pre-existing disorders was inappropriate and counterproductive.

Other viewpoints were also elaborated. A few respondents found the concept of PTSD to be a useful formulation for the problems that many people may experience. These proponents of PTSD distinguished a normal, distressing response to disaster from the psychological impact of events that are beyond the capacities of individuals to cope with, thereby constituting disorder. As one respondent explained, although most people remain active and effective in the face of continuing hardship and threat, others do not. As another proponent explained: “Criticism of this concept fails to understand the purpose of a syndrome, that is, to have a more or

less similar language for professionals to treat their patients. It does not deny their suffering or the human dimension of their difficulties.” Another proponent declared: “It is a valid core construct, but it should be seen as scaffolding upon which the psychiatric healer constructs a multilayered picture upon the individual, the family, and the culture at large.” One respondent who was critical of the concept on clinical grounds, however, acknowledged its positive political impact: Widespread acceptance of PTSD may have helped increase the international study of human rights violations, such as torture.

Goals and Approaches for Mental Health Policy

Respondents were asked to consider two complementary goals for the mental health component of disaster recovery: (a) attention to individuals requiring support or treatment and (b) attention to social revitalization and community reconstruction. Respondents emphasizing clinical priorities argued that help-seekers who come to them for treatment rarely articulate direct concerns about rebuilding communities or “social worlds,” but they do have symptoms for which they want clinical treatment. Other respondents, however, argued that clinical categories are often irrelevant to the emotional suffering of these patients, that mental health problems identified from psychiatric screening for cases in relief settings are often not disabling, and that such problems of these patients do not differ substantially from the experience of the general population.

Respondents who discussed the needs of communities stressed the importance of (a) assessing the local sociocultural setting, (b) relating this context to the local formulation of problems, and (c) identifying features of the culture and community that suggest local ways of coping. These components of community assessment should guide the mental health component of relief efforts. Respondents also recognized the needs of particular vulnerable groups. These include not only psychiatric patients in treatment of pre-existing disorders and for whom services had been disrupted, but also other groups with particular needs, including women, children, and the elderly who may lack family support.

The rationale for early clinical interventions was based not only on the aim to relieve current suffering, but also on the assumption that early treatment prevents subsequent psychopathology. Psychological debriefing immediately after disaster (an intervention involving a systematic review of the experience of the event) was valued by some, referring to a one-off early intervention that was advocated vigorously in the past. Most respondents, on the other hand, were very critical of this approach, dismissing it as either useless or potentially harmful. One expert, reflecting on the plight of people in the unstable period immediately following disaster, explained, “There is nothing more inappropriate than mental

health experts trying to talk about feelings when they [the people surviving the disaster] are just trying to find out what happened to their family, children, or their homes.” Several respondents advocated ‘psychological first aid’, an intervention that aims to establish safety, emotional and social support and to ensure that basic needs are met (National Institute of Mental Health, 2002).

Some respondents were critical of efforts in the aftermath of disaster to apply counseling and psychotherapeutic approaches that have been developed for treating the psychopathology of western individuals in the normal course of their lives. Such arguments were based on a cultural critique and a disaster setting-specific critique. At one end of the spectrum of clinical versus social orientations, some respondents discounted the value of any clinical intervention, arguing instead that interventions that support efforts to achieve social justice would ultimately be more useful to relieve the disaster-related suffering of the population than clinical treatment of traumatized individuals.

Who should provide help? Several respondents criticized an overemphasis and reliance on outsider European and North American clinicians. Those who were skeptical of the value of transplanted expertise questioned its relevance across cultures and its high cost. They also suggested that a lack of experience in the local setting may complicate efforts to restore the viability of local institutions. Overall, the experts communicated caution, suggesting that outsiders must remain vigilant to the various and subtle ways in which they may impose their own values on communities, and thereby undermine efforts to restore the self-confidence of these communities and make them functional.

The sustainability of relief efforts was also a matter of concern. Respondents were wary of short-term programs and emphasized the importance of sustaining services beyond the acute phase, after the interest of donors and agencies has waned and many foreign assistance workers have returned home. From experience in East Africa one respondent emphasized the importance of developing a mental health infrastructure in advance and having it in place. Prior planning and development of a mental health services capacity, it was argued, would reduce vulnerability to the impact of disasters.

The importance of recruiting relief workers from the affected communities themselves was emphasized. Capable local personnel should be identified and recognized as community resources, including health care practitioners, traditional healers, and locally respected leaders. Although respondents identified such persons as an important resource, one respondent cautioned that in the face of major disasters, healers and leaders may be as seriously and adversely affected as anyone else and that it is not just their skills, but also their needs that must be considered, so that expectations of them may be reasonable. Several respondents emphasized the complexity of the social structures and interpersonal dynam-

ics of community leadership. Competition and factional conflicts may be problematic. One respondent pointed out that it was not enough to give “lip service from Northern agencies and NGOs” to the local context and local cultural values. Accordingly, ensuring that these values find their way into policy and action should be priority.

Keeping communities informed about the current status of the disaster and relief efforts was a high priority among social interventions identified by several respondents. People need access to all available information about their relatives and friends. In short, all respondents acknowledged, in one way or another, the importance of rebuilding social institutions and restoring the viability of communities. For some it was the social domains and for others the clinical services that took precedence.

Needed Research

Four broad areas of needed research were highlighted among the responses. First, clinical and psychiatric epidemiological field-based studies were advocated to characterize the nature, course, determinants, and distribution of disorders and associated disability. Several respondents encouraged research to identify determinants of resilience. Concerns about the quality of epidemiological field studies were discussed with reference to the need for culturally-validated instruments.

Second, in addition to psychiatric epidemiological study of psychiatric disorders, several respondents argued for complementary epidemiological study of the mental health problems affecting people in the community, which may be configured similarly or differently from professional concepts of disorder. Such research is advocated to clarify the local formulation of mental health problems with reference to their nature, meaning, and distribution in disaster-affected communities (*i.e.*, a cultural epidemiology; Weiss, 2001). Specified research needs also included fieldwork to determine “how the community is coping” and to identify local options and determinants of help seeking.

Third, studies were recommended to examine the effectiveness of specific interventions, especially those developed with reference to particular ideologies that may potentially limit their relevance across cultures. Respondents suggested that intervention studies should be complemented by evaluating alternative models of clinical and community services, assessing consumers’ views about services and interventions.

Fourth, research was suggested to study the impact of broad-based social and political interventions. Some respondents indicated the need for innovative and sensitive approaches to determine the impact of war crimes tribunals and other features of social policy.

DISCUSSION

Although our survey queried a small, selected sample of 17 experts, responses provided a qualitative account of the

relevant issues and a range of views indicating areas of consensus and controversy. The identified issues merit the attention of policymakers for disaster management in low and middle-income countries. Their views reflect a range of ideological orientations and a wealth of field experience. The fact that only 24% of our respondents live in low- or middle-income countries is a limitation of the survey and a symptom of the undesirable situation that, in general, mental health discourse tends to be dominated by individuals living in high-income Western European and North American countries (Patel et al., 2001; Saxena et al., 2003).

Respondents disagreed about the validity and usefulness of the PTSD concept; they also disagreed about the relative priority of trauma-focused clinical services and what these could reasonably be expected to achieve. Overall, quite a few respondents recognized the problems that have troubled vigorous critics of the PTSD concept (Bracken & Petty, 1998; Summerfield, 1999, 2000), but the diversity of responses also modulate or reject that critique.

Respondents agreed about many issues. Although they differed in the relative priority they attached to social interventions, almost all agreed on their importance. Among other areas of consensus, they agreed about the importance of careful community needs assessments, carefully examining the sociocultural contexts before commencing interventions, the importance of recruiting local relief workers and using appropriate local expertise, the importance of sustaining mental health interventions over time, the need to provide clinical care for pre-existing disorders; and the need for research and evaluation of various approaches and relief efforts. On the basis of this survey, we discuss several implications for mental health policy.

Sociocultural and Community Context

Interventions ought to be guided by careful preparation that includes assessment and consideration of the local sociocultural setting in which disaster occurs, including community resources, local perceptions of needs and problems, perceived causes of these problems, and ways of coping. Although one of our respondents advised, "Well, this is obvious: ask and look first," mental health professionals are typically trained to assess disorders, rather than a local formulation of needs with reference to community settings. Those who make such assessments need to consider their findings with reference to the frameworks of both social science and public health, and how these relate to mental health.

Balancing Clinical and Community Interventions

The mental health agenda for disaster relief must include complementary components that address both individual clinical needs and broader needs of community revitalization. Practical matters—such as access to information—

must have a high priority. Clinical services and community interventions should be complementary, but may become antagonistic if limited resources require sacrificing one for the other. Awareness of this danger should be considered in requesting and allocating resources for relief to avoid an unacceptable compromise.

The social component of interventions should make appropriate use of local resources and promote active community participation, recognizing both local capacities and their limitations. Because most activities and resources are currently focused on clinical services, rather than community action, more attention to the latter to correct the imbalance may be required. Community-based supports should make use of group interactions to build or restore social networks, to help communities rebuild institutions and infrastructures, and to enable people to return to previous activities or to develop acceptable alternatives.

Insofar as the social institutions and structures are in a disordered state, acknowledgment of that provides a reference point to orient evaluation of the condition of individuals. Although clinical and other supportive services can be helpful for distressed individuals in disordered communities, acknowledging the status of the community brings required perspective to questions of priorities. Mental health services can be and should be incorporated into primary health care and other general health services, whether or not the community is affected by or anticipates disaster (WHO, 2001a). Separate services for distinct groups of trauma survivors should be avoided. Health professionals should identify those in need of clinical services, especially among particularly vulnerable groups, such as patients previously in treatment of psychiatric disorders and those who have been functionally incapacitated by their experience of the disaster. Yet, aid programs should refrain from applying blanket trauma-focused clinical interventions to a large proportion of a population, solely because the community as a whole has been exposed to disaster.

Mental Health Problems and Psychiatric Disorders

Clinical and social interventions should aim to address a wide range of mental health problems and disorders, rather than becoming preoccupied solely with PTSD. Exclusive consideration of PTSD and the requirement that only a diagnosis of disorder may justify the attention of mental health professionals unnecessarily restricts potentially useful assistance. To facilitate clinical interventions in the absence of diagnosed psychopathology, a role for V codes in the DSM or Z codes in the ICD diagnostic systems could be considered (Blank, 1993). Identifying immediate problems and helping to cope with them may effectively provide worthwhile assistance.

Research

The 4 areas of research discussed by our expert respondents should be pursued. An integrated approach to community needs assessment should recognize the importance of both psychiatric and cultural epidemiological approaches. Although methods for the latter are less well-known, experience is now available that may be adapted to meet research needs (M. Weiss, 2001, W. Weiss et al., 2000, Wilk and Bolton, 2002). Research to document the impact of clinical and social interventions is important. Such experience and documentation should guide and prepare mental health systems to respond more effectively to new challenges that will regrettably and inevitably arise.

ACKNOWLEDGMENTS

The authors thank the following expert respondents who gave their time and thoughtful consideration to our queries: Drs. JK Boehnlein (Oregon Health Sciences University, United States), P Bracken (University of Bradford, United Kingdom), S Fernando (University of Kent, UK), R Gordon (Royal Children's Hospital, Australia), JL Herman (Harvard University, US), L Jacobsson (Umea University, Sweden), JTVM de Jong (Transcultural Psychosocial Organization, the Netherlands), S Kaaya (Muhimbili University College of Health Science, Tanzania), JD Kinzie (Oregon Health Sciences University, US), AM Kos (Centre for Psychosocial Help to Refugees, Slovenia), R Littlewood (University College London, UK), AC McFarlane (University of Adelaide, Australia), B Raphael (Centre for Mental Health, Australia), I Sayil (University of Ankara, Turkey), DJ Somasundaram (University of Jaffna, Sri Lanka), D Summerfield (Medical Foundation for the Care of Victims of Torture, UK), and L van Willigen (The Netherlands). Advice of Drs. S Jadhav, R Raguram, and AT Yilmaz in the preparation and planning of this study, and financial support of the Swiss National Science Foundation, Cultural Research for Mental Health, Grant #32-51068.97, are gratefully acknowledged.

REFERENCES

- Blank AS Jr (1993) Suggested recommendations for DSM-IV on course and subtypes. In Davidson JRT, Foa EB (Eds), *Posttraumatic Stress Disorder: DSM-IV and Beyond* (pp 237-239). Washington, DC: American Psychiatric Press.
- Boehnlein JK, Kinzie JD (1992) Commentary. DSM diagnosis of posttraumatic stress disorder and cultural sensitivity: a response. *J Nerv Ment Dis.* 180:597-599.
- Bracken P, Petty C (Eds) (1998) *Rethinking the Trauma of War*. London: Free Association Books.
- de Jong JTVM (2002) *Trauma, War, and Violence: Public Mental Health in Socio-Cultural Context*. New York: Kluwer.
- de Ville de Goyet C (2000) Stop propagating disaster myths. *Lancet* 356: 762-764.
- Dyregrov A, Gupta L, Gjestad R, Raundalen M. (2002). Is the cultural always right? *Traumatology* 8:1-10. <http://www.fsu.edu/%7Etrauma/v8/CultureRight.PDF>.
- Eisenbruch M (1992) Toward a culturally sensitive DSM: cultural bereavement in Cambodian refugees and the traditional healer as taxonomist. *J Nerv Ment Dis.* 180:8-10.
- Green B, Friedman M, de Jong JTVM, Solomon S, Keane T, Fairbank J, Donelan B, Frey-Wouters E (in press). *Trauma in War and Peace: Prevention, Practice and Policy. Report to the United Nations* New York: Kluwer.
- National Institute of Mental Health (2002) *Mental Health and Mass Violence: Evidence-based Early Psychological Interventions for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices*. NIH Publication No. 02-5138. Washington DC: US Government Printing Office.
- Norris FH, Friedman MJ, Watson PJ (2002) 60,000 disaster victims speak: Part II. summary and implications of the disaster mental health research. *Psychiatry.* 65:240-260.
- Patel V, Sumathipala A (2001) International representation in psychiatric literature. *Br J Psychiatry.* 178:406-409.
- Saxena S, Levav I, Maulik P, Saraceno B (2003) How international are the editorial boards of leading psychiatry journals? *Lancet.* 361:609.
- Silove D, Ekblad S, Mollica R (2000) The rights of the severely mentally ill in post-conflict societies. *Lancet.* 355:1548-1549.
- Summerfield D (1999) A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Soc Sci Med.* 48:1449-1462.
- Summerfield D (2000) War and mental health: a brief overview. *Lancet.* 321:232-235.
- Weine S, Danieli Y, Silove D, Van Ommeren M, Fairbank JA, Saul J; for the Task Force on International Trauma Training (2002) Guidelines for international training in mental health and psychosocial interventions for trauma exposed populations in clinical and community settings. *Psychiatry* 65:156-164.
- Weiss MG (2001) Cultural epidemiology: introduction and overview. *Anthro Med.* 8:5-29.
- Weiss W, Bolton P, Shakar A (2000). *Rapid Assessment Procedures (RAP): Addressing the Perceived Needs of Refugees and Internally Displaced Persons through Participatory Learning and Action*. Baltimore: CERTI and USAID.
- Wilk CM, Bolton P (2002) Local perceptions of the mental health effects of the Uganda acquired immunodeficiency syndrome epidemic. *J Nerv Ment Dis.* 190:394-7.
- WinMax (2000) *WinMax Software for Qualitative Data Analysis*. Berlin: BSS Media.
- World Health Organization (2001a) *World Health Report 2001. Mental Health: New Understanding, New Hope*. Geneva: Author.
- World Health Organization (2001b) *Atlas: Mental Health Resources in the World*. Geneva: Author.