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MASSON

The World Psychiatric Association (WPA)

The WPA is an association of psychiatric societies aimed to increase knowledge and skills necessary for work in the field of mental health and the care for the mentally ill. Its member societies are presently 130, spanning 113 different countries and representing more than 180,000 psychiatrists. The WPA organizes the World Congress of Psychiatry every three years. It also organizes international and regional congresses and meetings, and thematic conferences. It has 64 scientific sections, aimed to disseminate information and promote collaborative work in specific domains of psychiatry. It has produced recently several educational programmes and series of books. It has developed ethical guidelines for psychiatric practice, including the Madrid Declaration (1996). Further information on the WPA can be found on the website www.wpanet.org.

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WPA and disaster response: new policies and actions

JUAN E. MEZZICH

President, World Psychiatric Association

As we have come to know, massive natural disasters are becoming increasingly frequent, affecting directly many areas of the world and indirectly humanity as a whole. The WPA, embodying 130 national psychiatric societies, over 180,000 psychiatrists, and 64 scientific sections, feels concerned to respond solidariously in each case to the suffering of the directly involved psychiatric societies, individual colleagues and the population they serve.

Our response, based on our constitution and particular expertise and resources, must focus on assisting our member societies and related health professional groups to fulfill their responsibilities in helping local populations and organizations to deal with the psychosocial consequences of disasters. This would often involve educational efforts based on adequate situational assessments and carefully prepared and culturally informed health actions. These activities would be promoted by engaging and assisting competent and committed local member societies and groups organizationally and financially to carry out assessments and action programs in coordination with national and international efforts, including those of the World Health Organization (WHO).

INVOLVED WPA STRUCTURES

The work of WPA on disaster response is being operationalized through the following WPA structures:

- The WPA Executive Committee, for policy formulation and monitoring.
- The Institutional Program on Disasters and Mental Health, chaired by G. Christodoulou (Greece), for broad operational coordination.
- The Scientific Section on Disasters, chaired by M. Benyakar (Argentina), for the development of academic resources. Other relevant contributors of academic materials include the Sections on Developing Countries, Emergency Psychiatry, Rural Psychiatry, and Women's Mental Health among others.
- Appointed local task forces (incorporating Zonal Representatives, Member Societies and other local groups), for basic situational assessment and the preparation of strong and budgeted protocols. Presently, these task forces include the following: a) the WPA South Asian Tsunami Task Force chaired by P. Deva (Malaysia), b) the WPA Inter-Sectional Task Force on Katrina and related North American Hurricanes chaired by J. McIntyre (USA), and c) the WPA Task Force on the Kashmir Earthquake chaired by H. Chaudhry (Pakistan) and co-chaired by J.K. Trivedi (India).

The functioning of the above listed central and local structures will be overseen by the WPA President. Furthermore, H. Herrman (Australia) (WPA Secretary for Publications) will assist as needed the Institutional Program and the local task forces, particularly those in WPA Region IV (Asia/Australasia).

WPA DISASTERS FUND

A significant structure to help the implementation of the above policies is the WPA Disasters Fund. It was originally established by the 2002-2005 Executive Committee through an allocation of US$ 50,000 from central funds, an amount used for a planning meeting in Cairo, for the development of an operational package by the WPA Disasters Section, and for training programs in Sri Lanka and Indonesia.

The new Executive Committee agreed recently to advance US$ 10,000 for the WPA Task Force on the Kashmir Earthquake to support the completion and documentation of an initial assessment of disaster related psychosocial training needs and to prepare strong protocols for specific projects.

The new plan also calls for donations to the Disasters Fund both from WPA Member Societies and from foundations and relevant industry. These funds will be used to cover quickly assigned allocations for initial situational assessments of future disasters and to support well prepared protocols of greater magnitude.

COMING TO THE FIELD IN AGRA

A field meeting with key WPA central and local leaders on disasters was held on December 3, 2005 within the framework of the International Conference of the South Asian Association for Regional Cooperation (SAARC) in Agra, India. This meeting reviewed the new WPA policy and plans on disasters response, emphasizing the need for proactive communication with governments, WHO and Member Societies when a disaster occurs (readiness) as well as in ensuring preparedness for disaster response. Also suggested was the formation of national sections on disasters within Member Societies linked to the WPA Disasters Section and the establishment of a database on disaster leaders, experts, resources, and experiences to be housed in the WPA website.

A preliminary evaluation of the South Asian Tsunami

Task Force documented the limitations of psychosocial responses overall and the critical role of psychiatrists in acute care and rehabilitation efforts. It was reported that the WPA assigned funds for training programs in Sri Lanka and Indonesia where put to good use, with a further specification in process.

Concerning the Task Force on the Kashmir Earthquake, it was proposed that its membership include the presidents of the Pakistani and Indian Psychiatric Societies, currently A. Malik and S. Nambi, as well as A. Javed and U. Niaz, in addition to co-chairs H. Chaudhry and J.K. Trivedi. An Advisory Group will include the other WPA Zonal Representatives and Member Societies in Region IV.

COLOPHON

When a major disaster strikes, often with enormous mental health consequences to individuals and communities, the increasingly small world in which we live must come together in partnership, and WPA has a significant role to play in it. The new policies and plans on disasters response outlined above reflect WPA commitment to engage all its structures (Executive Committee, Institutional Program, Sections, Zonal Representatives, and Member Societies) to respond effectively to the challenges we face and to enhance our capacity to learn from these experiences. New steps will follow as well as efforts to appraise their impact.

PERSPECTIVE

The Katrina disaster and its lessons

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Disasters by their nature are unexpected events that catch most of organized society in a crisis. Despite previously prepared protocols for interventions, the nature of disasters creates and brings to the surface the underlying dysfunctions that existed prior to the event in any local and national governments.

Most recently, the hurricanes that tormented the southern coast of the USA and the subsequent flooding of New Orleans are only now being recognized as a focus for much needed mental health intervention. What existed there and the governmental response was reminiscent of those that occur in third world countries but, surprisingly, this was rather existing in a portion of one of the most highly developed and wealthy nations in the world.

What happened in New Orleans is a good example of response to disasters in general. While much of the USA was preparing for an upcoming end of summer holiday, New Orleans was preparing for an all city evacuation before the forecasted hurricane, dubbed Katrina, would sweep through the Gulf of Mexico and hit land. Some people opted to leave their cars behind and evacuate to either a large convention center or the Superdome sports arena. Others drove in ravaging traffic jams for hours to reach safety away from the path of the hurricane. Others jammed the airport to fill flights to safer cities. When the hurricane's winds subsided, some people went back home, others were relieved and knew the decision to stay boarded up in their homes was correct. Yet, within hours, one of the levees holding water along a side canal from the Mississippi River broke, and water poured over its brim and onto the land far below the canal water level. Houses were flooded to their rooftops and whole communities were covered in water. People who could not get out of their attics fast as the water rose perished in the floods. Others died because they could not swim in the deep current or because they stayed for days on a rooftop without aid. While the world watched TV newscasts of this event, rescue was slow and the TV viewers were helpless to respond to the people interviewed pleading for help and to the doctors in the convention center and streets saying that massive help was needed and little had arrived. The overcrowded convention center and Superdome were not adequately supplied with drinking water or food. The Red Cross set up shelters, but they were not enough. The Federal Emergency Management Agency (FEMA) slowly became aware that their response efforts were not adequate. The local government of New Orleans, despite setting up a command center in a downtown New Orleans hotel ballroom, remained dysfunctional and lacked essential communication with both the state and federal governments. Each blamed the other and yet competed to do better. Meanwhile people continued to die on rooftops and not receive food and water.

A vast number of survivors lost their homes, that became rubble or, if remained once the water level receded, were covered inside with mold. All belongings were unsalvageable. Insurance agents began coming to New Orleans to minimize the liability of their companies, leaving many homeowners vulnerable. The FEMA promised in public what they could not give in private. Although checks could come in the mail to pay bills, no mail could be delivered. Bills still came for electricity and telephone, although these services were not restored or the houses they corresponded to no longer existed. Although slow, the FEMA did find temporary housing for most and financially enabled many to begin to rebuild at least partially.

The entire city medical care system was destroyed. The hospitals were closed. Patients could not find their doctors, as offices were closed and many of the doctors themselves lost their homes. Jobs were lost and employees were lost to the employers even if the business could be reopened. Medical records were lost in the rubble and floods, and many patients who showed up in clinics only knew the color of their pills, not what they were. Pharmacies were closed and if re-opening had to discard their supplies because the medications had spoiled in the heat and new deliveries were not coming quickly. Laboratories were also not available to process blood tests, and delivery trucks were unavailable to send the samples elsewhere.

Aside from the clear victims and survivors, the first responders need mention. The police and firemen, and local citizens who rescued survivors and for weeks pulled the deceased out of flooded homes, all were in need of support. Some in extreme cases went unnoticed until they suicided. Many of the responders were also victims, as they lost homes and relatives as well. They were housed on cruise ships in the harbor and hotels that were not damaged, but lost much of their possessions.

Once the remaining occupants obtained food, water, clothing and temporary shelter, the symptoms that emerged were insomnia, anxiety, panic and depression. Still the people from New Orleans, the first responders both local and coming from afar, as well as those people who indirectly were affected by daily TV news reports, become continuously tearful with reminders.

Much of the above description is reminiscent of countless other natural or man-made disaster responses, with disorganization of those in command and competition among aid organizations. Two months after the disaster, when the basic needs were met for many, mental health issues came into the forefront.

The new specialty of disaster psychiatry has recently gained recognition, after the September 11, 2001 terrorist attacks on New York City and Washington. However, in New Orleans, just as in many developing countries, religious support was the mainstay for hope and peace. Very few mental health professionals in New Orleans were trained in the evidence-based and now acceptable treatments of choice.

Education about the need for early treatment, and identification of the most vulnerable for serious psychiatric consequences is needed, so that guidelines can be established and rumors about popular untested or even known harmful treatments can be quelled.

Prevention of mental and behavioural disorders: implications for policy and practice

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There is sufficient evidence indicating the efficacy of interventions in reducing risk factors, increasing protective factors, preventing psychiatric symptoms and new cases of mental disorders. Macro-policy interventions to improve nutrition, housing and education or to reduce economic insecurity have proven to reduce mental health problems. Specific interventions to increase resilience in children and adolescents through parenting and early interventions, and programmes for children at risk for mental disorders such as those who have a mentally ill parent or have suffered parental loss or family disruption, have also shown to increase mental well-being and decrease depressive symptoms and the onset of depressive disorders. Interventions for the adult population, from macro-policy strategies, such as taxation of alcohol products or workplace legislation, to individual support for those with signs of a mental disorder, can reduce mental health problems and associated social and economic burdens. Exercise, social support or community participation have also shown to improve mental health of older populations. Public mental health will benefit from continuing building the evidence base through combining different evaluation methods across low, middle and high income countries. The translation of evidence into policy and practice calls for action at the international, national and local level, including building capacity, advocacy, mainstreaming mental health into public health and other policies and securing infrastructures and sustainability. Mental health professionals have an important role to play in improving the evidence on prevention and promotion in mental health, in engaging relevant stakeholders for developing programmes, and as professional care providers in their practice.

Key words: Prevention, promotion, mental health, evidence, intervention effectiveness

The potential and possibilities for prevention of mental and behavioural disorders have increased substantially in recent years. This paper provides a brief review of the place of prevention within the overall public health strategy for mental and behavioural disorders, summarizes the current evidence for generic prevention interventions, and makes suggestions on how these can become part of policy and practice. For further information, the reader is referred to two publications produced by the World Health Organization (WHO) (1,2).

Universal, selective and indicated preventive interventions are included within primary prevention. Universal prevention targets the general public or a whole population group that has not been identified on the basis of increased risk. Selective prevention targets individuals or subgroups of the population whose risk of developing a mental disorder is significantly higher than average, as evidenced by biological, psychological or social risk factors. Indicated prevention targets high-risk people who are identified as having minimal but detectable signs or symptoms foreshadowing mental disorder or biological markers indicating predisposition for mental disorder, but who do not meet diagnostic criteria for disorder at that time.

Secondary prevention seeks to lower the rate of established cases of the disorder or illness in the population (prevalence) through early detection and treatment of diagnosable diseases. Tertiary prevention includes interventions that reduce disability, enhance rehabilitation and prevent relapses and recurrences of the illness. This paper focuses on primary prevention of mental disorders.

The distinction between mental health promotion and mental disorder prevention lies in their targeted outcomes. Mental health promotion aims to promote positive mental health by increasing psychological well-being, competence and resilience, and by creating supporting living conditions and environments. Mental disorder prevention has as its target the reduction of symptoms and ultimately of mental disorders. It uses mental health promotion strategies as one of the means to achieve these goals. Mental health promotion, when aiming to enhance positive mental health in the community, may also have the secondary outcome of decreasing the incidence of mental disorders. Positive mental health serves as a powerful protective factor against mental illness. However, mental disorders and positive mental health cannot be described as the different ends of a linear scale, but rather as two overlapping and interrelated components of a single concept of mental health (3). Prevention and promotion elements are often present within the same programmes and strategies, involving similar activities and producing different but complementary outcomes.

BUILDING THE EVIDENCE BASE FOR PREVENTION OF MENTAL AND BEHAVIOURAL DISORDERS

The call for evidence-based prevention and health promotion has triggered an international debate among researchers, practitioners, health promotion advocates and policy makers (4-12). Paraphrasing the definition of evidence-based medicine by Sackett et al (13), evidence-based prevention and health promotion is defined as the "conscientious, explicit and judicious use of current best evidence in making decisions about interventions for individuals, communities and populations to facilitate the currently best possible outcomes in reducing the incidence of diseases and in enabling people to increase control over and to improve their health". Evidence from systematic research aims to avoid uncertainty in decisions due to lack of information, or decisions based on biased assumptions, which might in turn lead to wasting time and resources or investing in interventions with detrimental outcomes.

In supporting decision making, the use of scientific evidence becomes especially important when the implications of a decision are large, such as the choice of a new preventive programme for national implementation. Given the high costs and the pressure for accountability in spending public money, such a decision needs to be based on solid evidence, showing that the programme works and can produce a return in investment. For this, the use of evidence on the cost-effectiveness of given interventions is also crucial.

Different dimensions need to be taken into account when estimating the value of scientific evidence. First, evidence needs to be evaluated in terms of its quality, defined by the appropriateness of used research methods, to avoid biased observations and invalid conclusions. Several meta-analyses have found higher effect size in studies that use research designs rated as high in quality (5,14,15). Secondly, the value of the outcomes themselves, including the strength and type of effects, will also have to be appraised. Thirdly, the value of scientific evidence should be evaluated in terms of its actual use and impact for decision making. Finally, the value of the evidence will have to be combined with other indicators, also essential when considering the dissemination or adoption of prevention programmes, such as the transferability, feasibility and adaptability of programmes to other situations or cultures (16,17).

In evaluating the quality of the evidence, probably one of the "hottest" issues in the debate is whether randomized controlled trials (RCTs) should be considered the best design to warrant internal validity in complex interventions. Although the strength of RCTs is widely recognized and used in prevention research, many scientists in this field have expressed serious objections to accept this design as the one and only gold standard (6,12,18-23). RCTs are designed to study causal influences at individual level using mono-component interventions in a highly controlled context and thus are primarily suitable for evaluating clinical or preventive interventions at individual or family level. Many preventive interventions address whole schools, companies, communities or populations. They use multi-component programmes in a dynamic community setting, wherein many contextual factors are hardly controllable. The strict RCT design does not fit well in this context and, to retain its advantages in the context of community interventions, randomizations must be done at larger unit levels such as school classes, whole schools or communities. However, the feasibility of such randomized community designs is limited for practical, political, financial or ethical reasons. In those cases where, for example, ethical objections impede the use of randomization, quasi-experimental studies, using matching techniques to reach comparability between experimental and control groups, and time-series designs offer valuable alternatives.

The building of the evidence base requires a stepwise and incremental approach applying different methods depending on the information needed for a given decision. International exchange of evidence through common databases is essential for developing a strong evidence base, and for understanding the impact of cultural factors.

ADDRESSING RISK AND PROTECTIVE FACTORS

Risk factors are associated with an increased probability of onset, greater severity or longer duration of major health problems. Protective factors refer to conditions that improve people's resistance to risk factors and disorders: they have been defined as those factors that modify, ameliorate or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome (24).

There is strong evidence on risk and protective factors and their links to the development of mental disorders (25,26). Both risk and protective factors can be individual, family-related, social, economic or environmental in nature. Mostly it is the cumulative effect of the presence of multiple risk factors, the lack of protective factors and the interplay of risk and protective situations that predisposes individuals to move from a mentally healthy condition to increased vulnerability, then to a mental problem and finally to a full-blown disorder.

Major socioeconomic and environmental determinants for mental health are related to macro-issues such as poverty, war and inequity. For example, poor people often live without the basic freedoms of security, action and choice that the better-off take for granted. They often lack adequate food, shelter, education and health; deprivations keep them from leading the kind of life that everyone values (27). Populations living in poor socioeconomic circumstances are at increased risk of poor mental health, depression and lower subjective well-being (28). Other macro-factors such as urbanization, war and displacement, racial discrimination and economic instability have been linked to increased levels of psychiatric symptomatology and psychiatric morbidity.

Individual and family-related risk and protective factors can be biological, emotional, cognitive, behavioural, interpersonal or related to the family context. They may have their strongest impact on mental health at specific sensitive periods along the lifespan, and even have impact across generations. Table 1 enumerates the main factors that have been found to be related to the onset of mental disorders.

Table 1 Risk and protective factors for mental health and mental disorders

Risk factors	Protective factors
Biological	*Psychological*
Chronic insomnia	Ability to cope with stress
Chronic pain	Ability to face adversity
Early pregnancies	Adaptability
Genetic risk factors	Autonomy
Low birth weight	Early cognitive stimulation
Medical illness	Exercise
Neurochemical imbalance	Feelings of security
Perinatal complications	Feelings of mastery and control
	Literacy
Psychological	Positive attachment and early bonding
Academic failure and scholastic demoralization	Problem-solving skills
	Pro-social behaviour
Attention deficits	Self-esteem
Communication deviance	Skills for life
Emotional immaturity and dyscontrol	Social and conflict management skills
Excessive substance use	Socioemotional growth
Loneliness	Stress management
Poor work skills and habits	
Reading disabilities	*Social*
Sensory disabilities or organic handicaps	Safe maternal behaviour during pregnancy
Social incompetence	Good parenting
	Positive parent-child interaction
Social	Social support of family and friends
Caring for chronically ill or dementia patients	Mental health promoting school and workplaces
Child abuse and neglect	Safe and supportive communities
Elder abuse	
Exposure to aggression, violence and trauma	
Family conflict or family disorganization	
Low social class	
Parental mental illness	
Parental substance abuse	
Personal loss – bereavement	
Stressful life events	
Substance use during pregnancy	

Preventive interventions should address malleable determinants, including disease-specific as well as more generic risk and protective factors, which are those common to several mental health problems and disorders. Interventions that successfully address such generic factors may generate a broad spectrum of preventive effects. There are also interrelationships between mental and physical health: for example, cardiovascular disease can lead to depression and vice versa. Mental and physical health can also be related through common risk factors, such as poor housing leading to both poor mental and physical health.

Major increase in understanding is needed of the relations between different mental disorders and between mental health and physical health, and of the developmental pathways of generic and disease-specific risk factors leading to mental ill-health. However, there is sufficient evidence to warrant governmental and non-governmental investments in the development, dissemination and implementation of evidence-based programmes and policies. Those interventions that address risk and protective factors with a large impact or that are common to a range of related problems, including social and economic ones, will be most cost-effective and attractive to policymakers and other stakeholders.

THE EVIDENCE ON MACRO-STRATEGIES TO REDUCE THE RISK OF MENTAL DISORDERS

Changes in policy, legislation, and resource allocation can provide countries and regions with substantial improvements in mental health of the population. In addition to decreasing the risk of mental disorders and improving mental health, such changes have also been proven to positively impact on the overall health, social and economic development of societies.

There is strong evidence that improving nutrition and development in socioeconomically disadvantaged children can lead to healthy cognitive development, improved educational outcomes and reduced risk for mental ill-health, especially for those at risk or who are living in impoverished communities. The most effective intervention models are those that include complementary feeding, growth monitoring and promotion. These models combine nutritional interventions (such as food supplementation) with counselling and psychosocial care (e.g., warmth, attentive listening) (29). Growth charts (which plot the weight of the child against the expected weight) have also been suggested to be cost-effective (30). In addition, iodine plays a key role in preventing mental and physical retardation and impairment in learning ability (30). Iodine supplementation programmes which iodize salt or water ensure that children obtain adequate levels of iodine. Global efforts such as those supported by the United Nations Children's Fund (UNICEF) have led to 70% of the world's households using iodized salt. This protects 91 million newborns from iodine deficiency (31) and indirectly prevents related mental and physical health problems.

Poor housing has been used as an indicator of poverty and targeted to improve public health and reduce inequalities in health. A recent systematic review on the health effects of housing improvement suggests a promising impact on physical and mental health outcomes. This includes improvements in self-reported physical and mental health and less mental health strain, as well as broader positive social impacts on factors such as perceptions of safety, crime and social and community participation (32).

Low literacy and low levels of education are major social problems in many countries, particularly in South Asia and sub-Saharan Africa, and tend to be more common in women. Lack of education severely limits the ability of individuals to access economic entitlements. While there have been impressive gains in improving literacy levels in most countries through better educational programmes targeting children, there is much less effort directed to today's adult illiterates. It is expected that programmes aimed at improving literacy, in particular targeting adults, may have tangible benefits in reducing psychological strain and promoting mental health. Ethnographic research in India, for example, has noted that literacy programmes have significant consequences beyond the acquisition of specific skills (33). By bringing women together in new social forms that provided them with information about and ideas from wider worlds, the classes were potential catalysts for social change. By participating in campaigns as volunteer teachers, impoverished literate women and girls gained a sense of pride, self-worth and purpose. The positive mental health impact was mediated through a number of pathways, including acquisition of numeracy skills which reduced the risk of being cheated, greater confidence in expressing one's rights and a reduction of barriers to accessing opportunities. All of these outcomes have been associated with protection against mental ill-health and reducing the risks for mental disorders.

In many developing countries, economic insecurity is a consistent source of stress and worry that can lead to symptoms of depression, mental disorders and suicide. Non-governmental organizations, such as the Bangladesh Rural Advancement Committee (BRAC), have developed programmes for poverty alleviation targeting credit facilities, gender equity, basic health care, nutrition, education and human rights issues. Provision of loans from such sources may reduce the risk of mental illness by removing a key cause of stress: the threat posed by the informal moneylender. An evaluation of the BRAC poverty alleviation programmes, which reach out to millions of the poorest people in Bangladesh, indicates that psychological well-being of women who are BRAC members is better than those who are not (34).

Many community interventions have focused on developing empowering processes and building a sense of ownership and social responsibility within community members. An example is the Communities that Care (CTC) Programme, which has been implemented successfully in several hundred communities in the USA and is currently being adopted and replicated in the Netherlands, England, Scotland, Wales and Australia. The CTC engages communities to implement violence and aggression prevention systems, through the use of local data to identify risks and develop actions (35). Action includes interventions working simultaneously at multiple levels: the community (e.g., media, policy change), the school (e.g., changing management or teaching practices), the family (e.g., parent training) and the individual (e.g., social competence).

Effective regulatory interventions for addictive substances that can be implemented at international, national, regional and local levels include taxation, restrictions on availability and total bans on all forms of direct and indirect advertising (36).

Price is one of the largest determinants of alcohol and tobacco use. A tax increase that raises tobacco prices by 10% reduces the consumption of tobacco products by about 5% in high income countries and 8% in low and middle income countries. Similarly for alcohol, a 10% increase in price can reduce the long-term consumption of alcohol by about 7% in high income countries and, although there are very limited data, by about 10% in low income countries (36). In addition, increases in alcohol taxes reduce the incidence and prevalence of alcohol-related liver disease, traffic accidents and other intentional and unintentional injuries, such as family violence and the negative mental health impacts due to alcohol consumption.

Laws that increase the minimum legal drinking age reduce alcohol sales and problems among young drinkers. Reductions in the hours and days of sale and numbers of alcohol outlets and restrictions on access to alcohol are associated with reductions in both alcohol use and alcohol-related problems.

THE EVIDENCE OF INTERVENTIONS TO REDUCE STRESSORS AND ENHANCE RESILIENCE

Targeting vulnerable populations to decrease stressors and to enhance resilience can be effective in preventing mental and behavioural disorders and in promoting mental health. The following sections present some evidence across the lifespan.

Infancy, childhood and adolescence

Evidence from home visiting interventions during pregnancy and early infancy, addressing factors such as maternal smoking, poor social support, parental skills and early child-parent interactions, has shown health, social and economic outcomes of great public health significance (37). These include improvement of mental health both in the mothers and the newborns, less use of health services, and long-term reductions in problem behaviours after 15 years. These interventions can be also cost-effective when long-term outcomes are taken into account.

The Prenatal and Infancy Home Visiting Programme (38,39), a two-year nurse home visiting programme for impoverished adolescents pregnant for the first time, is an effective example with benefits both for the mothers and the newborns. RCTs showed reductions in low birth weight (increase of up to 400 g), a 75% reduction in preterm delivery, more than a two-fold reduction in emergency visits, and a significant reduction in child abuse among unmarried teens. Mothers showed an 82% increase in employment, and postponed their second child by more than 12 months. When children were 15 years of age, they were 56% less likely to have problems with alcohol or drugs, and reported 56% fewer arrests, 81% fewer convictions and a 63% reduction in the number of sexual partners. Families were better off financially and the government's costs for such families more than compensated for the programme's cost (38-41). However, not all home visiting programmes with nurses and social workers have been found to be effective (42), stressing the need to identify factors that predict intervention efficacy.

Interventions for children from impoverished families to enhance cognitive functioning and language skills have produced improved cognitive development, better school achievement and fewer conduct problems. The High/Scope Perry Preschool Project, for example, found benefits up to ages 19 and 27 on lifetime arrests (40% reduction) and a seven-fold economic return on the government's investment in the programme (43,44).

Parent management training programmes have also shown significant preventive effects, like the "The Incredible Years", which provides a behaviourally-based intervention that increases positive interactions between the child and the parent, improves the child's problem-solving behaviour and social functioning, and reduces conduct problems at home and school. The programme uses videotape modelling methods and includes modules for parents, school teachers and children (45,46).

Only two types of proactive strategies have proven some efficacy in preventing or reducing child abuse: home visiting programmes for high-risk mothers and self-defence programmes for school-aged children to prevent sexual abuse (47). Home visiting programmes, like the Prenatal and Infancy Home Visiting Programme described above, have shown, during the first two years, a drop of 80% of cases of verified child abuse or neglect. Self-defence programmes provide children with knowledge and skills to prevent their own victimization. These school-based programmes are widely implemented in the USA in primary schools. Well-controlled trials have shown that children do better in terms of knowledge and skills (48). However, no evidence from these programmes is yet available on reducing the rate of child abuse.

Children of parents with mental illness, for example children of depressed parents, are at as much as 50% risk of developing a depressive disorder before age 20 (49). Evidence indicates that the transgenerational transfer of mental disorders is the result of interactions between genetic, biological, psychological and social risk factors from as early as pregnancy and infancy (50). Interventions aimed to prevent transgenerational transfer address risk and protective factors such as the family's knowledge about the illness, psychosocial resilience in children, parent-child and family interactions, stigma and social network support. Controlled outcome studies on such programmes are still scarce, although promising, such as an RCT on a cognitive-oriented group programme, showing a decrease in new and recurrent depressive episodes from 25% in the control group to 8% in the prevention condition over the first year after the intervention, and from 31% to 21% respectively over the second follow-up year (51).

School-based programmes through social-emotional learning and ecological interventions improve mental health (52). Some interventions target the whole school in an integrated approach across years, while other interventions target only one part of the school (e.g., children in a given grade) or a specific group of students identified to be at risk. Outcomes have included academic improvement, increased problem-solving skills and social competence, as well as reductions in internalizing and externalizing problems such as depressive symptoms, anxiety, bullying, substance use and aggressive and delinquent behaviour.

Ecologically-focused interventions address contextual variables in the child's home or school. Programmes that restructure the school environment (e.g., School Transitional Environment Project) (53), influence the classroom climate (e.g., Good Behavior Game) (54) or the whole school climate (e.g., Norwegian Bullying Prevention Programme) (55) have shown to improve emotional and behavioural functioning and to prevent or reduce symptoms and associated negative outcomes.

Adolescents of divorced parents exhibit higher levels of school drop out, teen pregnancies, externalizing and internalizing problems, and a higher risk of divorce and premature mortality. Effective school-based programmes for children of divorced parents (e.g., Children's Support Group, Children of Divorce Intervention Programme) teach specific cognitive-behavioural coping skills, provide social support and reduce stigmatization, and have led to decreases in depressive symptomatology and behaviour problems at one-year follow-up (56-58). Parent-focused programmes to improve parenting skills and deal with emotions associated with divorce have improved mother-child relationship quality and reduced internalizing and externalizing problems in the children. One six-year randomized follow-up study revealed a difference in prevalence of mental disorders, where 11% of the adolescents in the experimental group had a one-year prevalence of diagnosed mental disorders, compared with 23.5% in the control group (59).

Parental death is related to higher symptoms of anxiety and depression, including clinical depression, behaviour problems and lower academic success. Although there are many interventions available for children suffering from bereavement, only a few have been evaluated in controlled trials (58). A successful example is an intervention targeting simultaneously children, adolescents and surviving caregivers, which led to positive parent-child relations, coping, caregiver mental health, discipline and sharing of feelings (60). Effects were stronger for those children who were more at risk, that is, those already showing symptoms at the start of the programme.

Adulthood

Work stress and unemployment can contribute to poor mental health and increase the incidence of depression, anxiety, burn-out, alcohol-related problems, cardiovascular illness and suicidal behaviour.

To reduce work stress, interventions may be directed at either increasing the coping capacity of the employee or at reducing stressors in the work environment. Three types of strategies can address work conditions: task and technical interventions (e.g., job enrichment, ergonomic improvements, reduction of noise, lowering the workload), improving role clarity and social relationships (e.g., communication, conflict resolution) and interventions addressing multiple changes directed both at work and employees. Notwithstanding the existence of national and international legislation with respect to the psychosocial work environment, which puts the emphasis on risk assessment and risk management, most programmes aim at reducing the cognitive appraisal of stressors and their subsequent effects, rather than at the reduction or elimination of the stressors themselves (61).

The most well-known universal interventions in response to job loss and unemployment tend to be legal policies governing unemployment insurance and welfare assistance or policies associated with improving job security. Their availability varies dramatically across different parts of the world. A variety of workplace policies are available to reduce the risk of job loss and unemployment, including job sharing, job security policies, cutbacks on pay and reduced hours. No empirical evidence is available on their potential to protect the mental health of employees, although their power to reduce stress related to unemployment is quite obvious.

A number of interventions support unemployed workers returning to paid employment, such as the Job Club and the JOBS Programme (61). These low-complexity and low-cost programmes combine basic job search skills with enhancing motivation, coping skills and social support. The JOBS programme has been tested and replicated in large-scale randomized trials in the USA (62-64) and Finland (65), showing increased rates of re-employment, better quality and pay of jobs obtained, increases in job search self-efficacy and mastery, and reductions in depression and distress.

Caregivers of chronically ill and elderly are at increased risk of suffering from high levels of stress and incidence of depression. Outcomes across a large range of controlled intervention studies on psycho-educational interventions for family caregivers of older adults have shown significant improvements in caregiver burden, depression, subjective well-being and perceived caregiver satisfaction (66). Psycho-educational interventions include providing information on the care receiver's disease and available resources and services, and training to respond effectively to disease-specific problems. Such interventions make use of lectures, group sessions and written materials.

Older populations

Different types of interventions have been successful to different degrees in improving the mental health of older populations, including exercise, improving social support through befriending, patient education among chronically ill elderly and their caregivers, early screening, interventions in primary care and programmes using life review techniques. Preventing craniocerebral traumas, high systolic blood pressure and high cholesterol levels seem also to be effective in reducing the risk of dementia.

For example, exercise, such as aerobic classes and Tai chi, provide both physical and psychological benefits in older populations, including increased life satisfaction, positive mood states and mental well-being, reductions in psychological distress and depressive symptoms, lower blood pressure and fewer falls (67).

Other interventions, although having shown promising effects, call for replication studies: for example, early geriatric screening and case management, including social services provision, as means to decrease depression and increase life satisfaction (68).

Although depression is common among the elderly, almost no controlled studies exist on depression prevention and suicide prevention for this group. Some evidence is available pointing at improved social relationships and fewer depressive symptoms among participants in a programme involving widows supporting other widows. Preliminary evidence is also suggesting that life review meetings and reminiscence therapy might reduce the risk of depression in the elderly, especially among nursing home residents (69), although benefits seem to disappear over time, suggesting the need for continued support.

Depression is also common in those who suffer from chronic or stressful physical conditions, but only a few examples of effective interventions exist in this area. Patient education techniques that teach about the prognosis and management strategies to deal with chronic conditions have shown short-term beneficial effects like reductions in depressive symptoms (70). Providing hearing aids to elderly people with hearing loss might also lead to better social, emotional and cognitive functioning and reductions in depression (71).

FROM EVIDENCE TO POLICY AND PRACTICE

The evidence generated over the last few decades and briefly summarized above shows that it is possible to reduce the risk of mental ill-health and prevent mental disorders. The critical task then is to facilitate the use of this evidence for policy and practice. This section briefly describes some of the steps and factors that can facilitate international, national and local efforts for prevention of mental and behavioural disorders.

International

Global advocacy is needed to enhance awareness and credibility of prevention efforts in mental health. The available evidence and information needs to be disseminated widely to policy makers and also to general public. Current knowledge and resources in prevention of mental disorders and mental health promotion are unevenly distributed around the world. International initiatives are needed to support countries that still are lacking capacity and expertise in this field. International training initiatives should be undertaken in collaboration with international organizations that already have the capacity for and experience of such initiatives, especially in middle and low income countries.

To strengthen the knowledge base, the capacity for prevention research, especially through international collaboration, needs to be expanded. This should include the development of a network of collaborating research centres responsive to the needs of low, middle and high income countries. Special attention of researchers is needed for: multisite and replication studies on the cultural sensitivity of programmes and policies; longitudinal studies to test the long-term impact of preventive interventions; research on the interrelatedness of mental, physical and social health problems; cost-effectiveness studies to identify the most efficient strategies and the value of prevention beyond its mental health benefits; and studies identifying effect predictors in order to improve effectiveness.

National

Governmental agencies need to develop national and regional policies on prevention of mental disorders and mental health promotion as part of public health policy and in balance with treatment and rehabilitation. Public policy approach should encompass horizontal actions through different public sectors, such as the environment, housing, social welfare, labour and employment, education, criminal justice and human rights protection. Governments should enhance national coordination of initiatives, practices and professionals for a more efficient use of resources.

Governments need to develop national and local infrastructures for prevention and promotion to work in collaboration within other public health and public policy platforms. Governments and health insurance companies should allocate appropriate resources for the implementation of evidence-based action, including: supporting capacity building across multiple sectors with assigned responsibilities; funding training, education, implementation and evaluation research; and stimulating coordination of the different sectors that are related to mental health.

High levels of comorbidity among psychiatric disorders and physical ill health call for integrated prevention strategies within primary and secondary health care. Supportive policies for prevention in primary and secondary care are needed, along with increased resources and training.

To sustain public health benefits over a longer period of time, it is crucial to develop communities' accountability to support sustainable strategies within health agencies. Governmental authorities and providers should select programmes and policies that can build on existing infrastructures and resources. Mental health promotion and prevention components should be structurally integrated with existing effective health promotion programmes and social policies in schools, workplaces and communities.

Local

Prevention policies need to be based on systematic assessments of public mental health needs. To enlarge the impact of preventive interventions on the mental health of whole populations, interventions that have the capacity to have a large reach in such populations need to be developed. Programme developers and providers need to be guided by evidence-based principles and conditions that can increase effectiveness and cost-effectiveness and can improve simultaneously mental and physical health and generate social and economic benefits.

Cultural adaptation and tailoring needs to be undertaken by service providers, especially when evidence-based programmes are adopted from other countries or cultures, or when they are implemented in communities and target populations that differ from the ones in which they were originally developed and tested. Although culturally modified, adaptations should be guided by principles of effective intervention and implementation. More insight needs to be developed into the transferability, opportunities for adaptation and reinvention of evidence-based programmes and policies across countries and cultures.

Practitioners and programme implementers are urged to ensure a high quality of programme implementation and to make use of tools to improve and ensure programme implementation with fidelity, such as manuals for programme provision, guidelines for effective implementation, training and supervision.

ROLES AND RESPONSIBILITIES OF MENTAL HEALTH PROFESSIONALS

Mental health professionals, including psychiatrists, psychologists, psychiatric nurses, social workers and other professionals with training in mental health, can and need to play a variety of roles to make prevention of mental and behavioural disorders a reality. These can be briefly summarized as follows.

As advocates

Mental health professionals are well placed to increase awareness and information on prevention among policy makers, other professionals and the general population, to create an environment that is more conducive to prevention efforts. Mental disorders are currently widely understood to be without recognizable causes and generally non-preventable. Correct information on the known causes and possible methods to decrease the incidence and improve the course of mental disorders needs to be made available widely to remove these myths.

As technical advisers on prevention programme development

Because of their knowledge base, mental health professionals need to advise public health planners and programme developers on the possibilities of initiating prevention interventions or integrating mental health components into existing programmes. The possibilities for this role are enormous, since most countries and communities have public health and social programmes that can serve the cause of prevention of mental disorders. Even if no changes are needed, an awareness that the programme may be having an impact on prevention of mental disorders helps to reinforce the need for the programme to be continued or expanded.

As leaders or collaborators in prevention programmes

In many cases, mental health professionals need to take an active role in initiating prevention programmes. This role can be as a leader or as an active collaborator, especially in an intersectoral programme. Some of the most effective prevention programmes have been initiated by mental health professionals working in close collaboration with other professionals.

As researchers

Mental health professionals need to take the challenge of further research on prevention of mental disorders. It is known that research on mental health as a proportion of overall research in health is far less than the proportionate burden of mental disorders; such research from low and middle income countries is even rarer (72-74). Even within the available mental health research, prevention research is scant. Mental health professionals and researchers need to correct this imbalance and create a better evidence base especially from low and middle income countries. Evidence base is particularly lacking on real world implementation, a gap that can be bridged by integrating a systematic evaluation component within existing prevention programmes. To overcome funding shortcomings, innovative proposals, especially if intersectoral in nature and targeted on multiple outcomes, are likely to generate increasing interest from potential funding agencies.

As professional care providers

Mental health professionals come in close contact with people with mental disorders and their families. The opportunities for primary prevention in these settings are enormous. People with one or more mental disorders (either active or in remission) are more likely to develop another mental disorder. Preventive interventions among these people, even though they may be in contact with mental health professionals, are often ignored. Examples include prevention of depression among people with a substance use disorder or of emotional disorders in a child with a specific developmental disorder.

Another way mental health care providers can assist in prevention efforts is by initiating prevention interventions in family members of those taking mental health care. Preventive approaches for children of parents with a diagnosed mental disorder, who are particularly at risk, can be highly effective but unfortunately not applied often. Mental health professionals need to balance their role of providing much needed care to the patients who are under treatment with preventing future need for care among their families.

CONCLUSIONS

Prevention of mental disorders is a public health priority. In view of the high and increasing burden of mental and behavioural disorders and the recognized limitations in their treatment, the only sustainable method for reducing their burden is prevention. Social and biological sciences have provided substantial insight into the role of risk and protective factors in the developmental pathways to mental disorders and poor mental health. Many of these factors are malleable and potential targets for prevention and promotion measures. There is a wide range of evidence-based general policies and strategies available for implementation to prevent mental and behavioural disorders in addition to those that are specific to particular disorders. Preventive strategies have been found to reduce risk factors, strengthen protective factors, decrease psychiatric symptoms and the onset of some mental disorders; they also contribute to better mental and physical health and generate social and economic benefits.

Although sufficient evidence warrants implementation, further efforts are needed to continue expanding the spectrum of effective preventive interventions, to improve their effectiveness and cost-effectiveness in varied settings and to continue strengthening the evidence base. This requires a process of repeated evaluation of programmes and policies and their implementation in addition to more controlled research studies.

Mental health professionals have several important roles to play in the prevention field. These include their roles as advocates, technical advisers, programme leaders, researchers and preventive care providers. These are challenging but likely to be very rewarding responsibilities. However, population-based outcomes can only be expected when sufficient human and financial resources are invested. Financial support should be allocated to the implementation of evidence-based prevention programmes and policies and to the development of required infrastructures. In addition, investments in capacity building at the country level should be promoted, providing training and creating a workforce of informed professionals. Much of this investment will need to come from governments, as they have the ultimate responsibility for population health. Current resources for prevention of mental disorders and mental health promotion are unevenly distributed around the world. International initiatives are needed to reduce this gap and to support low income countries in developing prevention knowledge, expertise, policies and interventions that are responsive to their needs, culture, conditions and opportunities.

Prevention of mental disorders and mental health promotion need to be an integral part of public health and health promotion policies at local and national levels. Prevention and promotion in mental health should be integrated within a public policy approach that encompasses horizontal action through different public sectors, such as the environment, housing, social welfare, labour and employment, education, criminal justice and human rights. This will generate "win-win" situations across sectors, including a wide range of health, social and economic benefits.

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SPECIAL ARTICLE

Management of borderline personality disorder: a review of psychotherapeutic approaches

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There are currently three major psychotherapeutic approaches to the management of borderline personality disorder (BPD): the psychodynamic, the cognitive-behavioral, and the supportive. There are special varieties within each: e.g., transference-focused psychotherapy (psychodynamic) or dialectic behavioral therapy (cognitive-behavioral). Though differing in basic conceptions and in methodology, all approaches aim at the amelioration of both the symptom-aspects that dominate the clinical picture at the outset, and the personality difficulties that remain apparent after the symptoms have been alleviated. The term "management" implies a focus on the more serious aspects of the borderline picture. These can be pictured hierarchically as to their level of seriousness, and there is universal agreement about the nature of this hierarchy. Therapists must pay attention first to suicidal and self-mutilative behaviors. Next, one deals with any threats to interrupt therapy prematurely. Third in order of seriousness: non-suicidal symptoms such as (mild to moderate) depression, substance abuse, panic and other anxiety manifestations, or dissociation. Psychopharmacological treatment will often be used adjunctively to help control any target symptoms, which usually fall into such categories as cognitive-perceptual, affect dysregulation, or impulsive/behavioral dyscontrol. Therapists must then be alert to any signs of withholding, dishonesty, or antisocial tendencies, since these have an adverse effect on prognosis. When all these disruptive influences are (to the extent possible) dealt with, therapists will next take up milder symptoms such as social anxiety or lability of mood. Throughout this initial process, the personality-disorder attributes of BPD will become more apparent, and will usually emerge with greater clarity, once the serious symptoms have been dealt with. The management issues will gradually be supplanted with the overlapping and enduring personality issues: inappropriate anger, abrasiveness, manipulativeness, demandingness, jealousy, "all-or-none" thinking and the extreme attitudes (idealization/devaluation) that accompany such thinking, masochistic traits, etc. Under ideal circumstances, the borderline patient will have "graduated" toward a higher level of function, where (acute) management issues have been adequately dealt with or have receded into the background. Psychotherapy, individual and group, becomes the dominant intervention, with such goals as psychic integration, skills training, and the fostering of long-range ambitions relating to friendships, partner choice, and work.

Key words: Borderline personality disorder, management issues, psychotherapeutic approaches, treatment priorities, accompanying symptoms

Within the domain of personality disorders, borderline personality disorder (BPD) has attracted the greatest attention; the literature devoted to it is more voluminous than that devoted to any of the other recognized personality disorders. This attention and large literature has more to do with the challenging nature of the condition and the difficulties attendant upon treating it, than to its frequency. In fact, the pooled prevalence for BPD has been estimated as 1.16% in the general population, which is less than the percentages for the antisocial, histrionic, obsessive-compulsive, and avoidant types (1).

Part of the difficulty in treating patients with BPD lies in the complexity of the condition, which is (in the beginning phases at least) accompanied almost invariably by one or more symptoms (assigned in the DSM-IV to Axis I), alongside its pathological personality traits, as enumerated in Axis II. Among the latter, some are themselves symptom-like: particularly the self-damaging acts (such as wrist cutting) and suicidal gestures (or actual attempts) that so often accompany BPD. Obviously these self-damaging behaviors require not only immediate attention but also skillful handling, since they are (initially, anyway) ego-syntonic in the borderline patients, and therefore not as easily discouraged as such painful and disruptive behaviors would be in ordinary persons.

As for the Axis I disorders that will be noted with regularity in BPD patients, the common ones include serious depressive episodes, bipolar II disorder, eating disorders (anorexia and/or bulimia), panic and other anxiety disorders, abuse of alcohol and other substances, and dissociative disorders. Also common in certain subgroups of BPD patients is post-traumatic stress disorder (PTSD). The subgroup most likely to experience concomitant PTSD is that of BPD patients who had been the victims of incest by an older family member, especially before age ten. Females are much more likely to have been subjected to such experiences than are males, and this may account in part for the female preponderance in samples of BPD patients (2-4).

The role of mood disorder in BPD has been a matter of debate ever since BPD won official status as a diagnosis in 1980 (DSM-III). Akiskal (5) and Stone (6) have taken the position that a significant proportion of BPD patients developed their personality disorder as an expression or offshoot of an underlying mood disorder, often of a recurrent depressive or a bipolar II type. The BPD diagnosis may become manifest in late adolescence or in the early 20s, before the bipolar disorder finds full clinical expression. This evolution may be more common in certain samples of BPD patients; less evident in others. Other authors (7), in contrast, did not find compelling evidence for the equivalence of BPD and any mood disorder.

The fact remains that many BPD patients experience serious depressive episodes at some point in their life course and that the suicide rate in long-term (10 to 30 year) follow-up studies is high, ranging from 3% (8) to 10% (3,9). Stanley and Brodsky (10) made the important point that suicidal behaviors in BPD are not always the expression of mood disorder, although the coexistence of BPD and major depression augments the risk for the more serious (including fatal) forms of suicidal behavior. The wrist cutting and other forms of self-mutilation common in BPD, and the minor, non-lethal suicidal gestures are often done to relieve unbearable interpersonal tension (rather than to end one's life) and are followed by the patient's feeling better. This sequence of events, which strikes most clinicians as paradoxical, influences the management of BPD, since it may be desirable not to hospitalize those who engage in self-mutilation by way of relieving tension, whereas those whose suicidal behaviors arise out of chronic feelings of depression and hopelessness may indeed require inpatient care.

The proper management of patients with BPD also requires taking into account the *totality* of their personality. Clinicians will rarely, if ever, encounter a borderline patient in whom BPD is the only diagnosable "category" (*à la* DSM) of personality disorder. Instead, as Oldham et al (11) have demonstrated, the panoply of pathological traits manifested by borderline patients will fulfill category-based criteria for other personality disorders as well: often one or two additional types; sometimes three or more. Most commonly, these accompanying types will be within DSM's "dramatic" cluster (cluster B): histrionic, narcissistic, or antisocial. Depressive-masochistic traits – not a category recognized in DSM, but well-described in the psychoanalytic literature (12) – are also commonly encountered, as are those of avoidant and (to a lesser extent) schizotypal personalities. Psychotherapy must be tailored to the admixture of traits noted in each BPD patient, assessed in dimensional terms (i.e., how much of each personality category is discernible in each case, and how intensely so). Both from the standpoint of amenability to psychotherapy and of ultimate prognosis, certain combinations prove easier and more rewarding to work with, and enjoy better long-term outcomes, while other combinations are more daunting and with less likelihood of success. BPD with depressive-masochistic features, for example, belongs generally to the more favorable group (such patients tend to be more introspective and motivated); BPD with narcissistic features has an intermediate prognosis; BPD with antisocial features will usually prove the most difficult to work with and carries a gloomy prognosis (13). BPD patients who lie and are generally dishonest will present enormous hurdles in the treatment, since such behavior is designed to evade or disparage, rather than cooperate with, the therapist (14). Other personality configurations that augur a poor prognosis, though not as ominously so as the antisocial, are the hypomanic and the paranoid (15). Among the BPD patients with marked paranoid "comorbidity" are those exhibiting pathological jealousy. Such patients often live at the very edge of delusion (or at times, on the other side) and cannot be reasoned out of their mistrust by argumentation, no matter how skillful, nor by proofs, no matter how compelling. One must try, in psychotherapy, to get below the surface where the mistrust resides, down to the lower layers of the psyche, where one will find the vast insecurity and self-doubt that feed the jealousy. Given the tendency of borderline patients with such jealousy to externalize, and to resist looking into themselves, this is no easy task. Some useful guidelines for dealing with such patients have been provided, nevertheless, by White and Mullen (16).

Psychopharmacological treatment will often be used adjunctively in the management of BPD to help control any target symptoms, which usually fall into such categories as cognitive-perceptual, affect dysregulation, or impulsive/behavioral dyscontrol. This aspect is not covered in the present review. It can be stated in brief, however, that the medications of choice for the cognitive-perceptual symptoms are atypical antipsychotics in low doses. For both affect dysregulation and impulsive/behavioral dyscontrol, the best approach is to use a selective serotonin reuptake inhibitor (SSRI). If an SSRI does not prove effective, one would then use a mood stabilizer such as lithium or valproate (17).

VARIETIES OF PSYCHOTHERAPY IN CURRENT USE FOR TREATING BORDERLINE PATIENTS

It has been customary in recent years, for didactic purposes, to divide the psychotherapeutic approaches to BPD into three main groups: psychoanalytically-oriented, cognitive-behavioral, and supportive. These approaches rest on differing theories and psychological foundations, such that practitioners trained in one approach tend to feel more "at home" in the techniques and tactics peculiar to that approach. In actual practice, and especially in the frequent crisis situations that characterize the course of BPD in the early phases, many therapists will find themselves relying upon tactics and interventions borrowed from an approach other than their primary one. Such shifts require a healthy measure of flexibility, besides lending an air of eclecticism to the practice of many who work intensively with borderline patients.

The psychodynamic therapies

The psychoanalytically-oriented or "psychodynamic" methods are based on the assumption that unconscious forces and conflicts are buffeting the borderline patient and are responsible for the sharply polarized attitudes and the often wildly oscillating behavioral patterns seen in BPD. Borderline patients, for example, tend to swing from adoration to contempt toward key figures in their lives (manifesting, in so doing, the defenses of idealization and devaluation). These attitudinal shifts may be triggered unpredictably via quite minor events in their interpersonal lives, such that other people experience the borderline person as unintegrated and existing only in extremes. The psychodynamic approach strives to promote psychic integration through the careful examination of the polarized attitudes (maintained outside awareness via the defense of splitting), making use of the fact that the therapist will soon be experienced, via the transference, as harboring the various strong feelings (of love, hatred, lust, jealousy, envy...) which stem actually from the borderline patient, but which for the time being exist outside the patient's awareness and get draped, so to say, around the shoulders of the therapist, via the defense of projective identification. During this process, strong countertransference feelings will be elicited in the therapist. But these feelings become highly useful material for the therapist to process and ultimately interpret back to the patient, by way of increasing the patient's conscious awareness of his basic conflicts and attitudes. The aim of the psychodynamic approach is, in general, to effect an integration of the hitherto disparate and split-off elements in the patient's psyche, in hopes this will lead to more appropriate attitudes toward other people and to more modulated behaviors in everyday life.

In the early phases of work with borderline patients, the therapist may be confronted with all manner of life-threatening or self-mutilative behaviors, interpersonal crises, disruptions in the treatment, and the like, necessitating the use of various supportive interventions. When suicidality or extreme impulsivity are present and necessitate hospitalization, psychodynamic considerations take second place to limit-setting and supportive interventions, until stability is restored. Gunderson (18) has given an excellent overview of the stepwise progression of treatment modalities that are brought into play, as the hospitalized BPD patient moves from dangerous to more calm and reflective modes of interaction. Gabbard (19) has drawn attention to the manner in which supportive interventions are routinely used at various points along the way in most psychodynamic therapies with BPD patients.

In recent years a number of treatment guidelines, or "manuals", have been developed for the major therapeutic approaches, including the psychodynamic. Kernberg et al (20), for example, have created a guideline for a transference-focused psychotherapy (TFP) for BPD, in which supportive interventions are avoided except in situations of considerable urgency. In England, Bateman and Fonagy (21) have published a comprehensive guideline for their mentalization-based treatment, which aims at fostering the capacity for reading the mental states of self and others more accurately (i.e., improving mentalization), so as to develop a more coherent sense of self and a better regulated set of emotions in relation to the external world. In their book the reader will find, however, an excellent summary of all the competing and widely used approaches to the management of BPD.

The psychodynamic approach of Kohut (22), known as self psychology, was developed primarily for ambulatory patients, especially those with narcissistic personalities. Some of the patients described by Kohut et al (23) exhibit the borderline personality organization as described by Kernberg, although Kohut and his collaborators expressed the view that the "borderline states" are not analyzable (23,24). The self-psychological approach utilizes, in any case, supportive interventions (expressions of sympathy, validation of the patient's perceptions of others, etc.) to a greater extent in working even with the milder (and ambulatory) end of the borderline spectrum. In working with borderline patients, Kohut sought to convert such patients over time into an "analyzable narcissistic personality" – if the therapist can, as Kohut put it, "stand the heat" of the stormy emotions that will surely emerge in the beginning of the work (25). Gunderson, Kernberg, and Bateman and Fonagy, in contrast, have extensive experience with BPD patients, whether ambulatory or hospitalized, and in their numerous publications make a compelling case for the efficacy of a psychodynamic approach in a respectably high proportion of borderline patients. Many clinical vignettes attesting to this impression are included in my book on treatable and untreatable personality-disordered patients (13). One can, at all events, speak of a spectrum of psychodynamic approaches, insofar as supportive interventions are either used or avoided. In Kernberg's TFP, supportive interventions are avoided insofar as possible, because these may "undermine working within the transference-countertransference paradigm and often lead to enactments of the countertransference" (14). Instead, TFP relies on such interventions as clarification (of confusing or poorly understood communications of the patient), confrontation (of the often paradoxical and polar-opposite attitudes BPD patients express concerning themselves and other people), and ultimately interpretations (aimed at making the patient aware of the split-off aspects of these disparate attitudes, so as to promote psychic integration). The presumption is that the important (and often turbulent) dynamic constellations in the borderline patient's everyday life will eventually play themselves out within the transference relationship, there to be brought to light, clarified, and modulated along more adaptive paths. Gunderson's approach, especially with hospitalized BPD patients, is more accepting of supportive interventions, especially at the outset; the ultimate aim is otherwise similar to that of TFP. Kohut's approach, as mentioned, is less adapted to the more severe borderline patients, and in any case relies importantly on supportive measures by way of building a therapeutic alliance.

The cognitive-behavioral therapies

The cognitive-behavioral approaches to the treatment of borderline patients place emphasis on observable behaviors and on the psychic schemata or "inner scripts" (habitual patterns of thought concerning the self and the interpersonal world, built up during one's developmental years). The behaviors and their underlying schemata have, in the evolution of BPD, become maladaptive for a variety of causative factors: hereditary predispositions, humiliations and other psychological hurts experienced at the hands of one's caretakers, and in some cases, outright traumata stemming from physical or sexual abuse. The early maladaptive schemata pertinent to BPD, outlined by Beck and Freeman (26), include such basic assumptions as (among others): "I'll be alone forever; no one will be there for me"; "I'm a bad person; I deserve to be punished"; "No one would love me if they really got to know me". These assumptions reflect some important themes relevant to BPD patients: namely, fear of abandonment, conviction of unlovability, and exaggerated guilt. The cognitive distortions typical of BPD patients involve (as we noted in discussing the dynamic approaches) polarized all-or-none attitudes, which Beck refers to as "dichotomous thinking". Though transference is not often discussed as such by cognitive-behavioral therapists, the phenomenon can readily be understood in cognitive language, as the responses on the part of the patient toward the therapist that are based on early embedded beliefs and expectations derived from past experience, rather than on the therapist as an actual and realistically-perceived individual. Therapy focuses on decreasing the tendency to dichotomous thinking, helping the patient develop better control over his emotions and impulses, and strengthening the patient's sense of identity.

In the last 25 years, the dialectic behavior therapy (DBT) developed by Marsha Linehan has become increasingly popular and respected as a method particularly for minimizing the tendency among BPD patients to make suicide gestures or attempts, or to indulge in other forms of self-harm. She and her colleagues have created a manual for carrying out DBT (27). This treatment approach includes the use of one individual session per week with a therapist, along with a weekly group session oriented toward skills training. Phone calls to the therapist are permitted (whereas they are discouraged in TFP), but with the proviso that the therapist will speak with the patient who is about to self-cut or make a suicide gesture, in the expectation that their conversation will lead to an ability on the part of the patient to gain self-control and to refrain from the self-damaging act. If the patient calls after having made the self-damaging act, then the call is cut short, as a means of reducing the "secondary gain" that might otherwise have been derived from the therapist's listening to what the patient had already in fact done. As for the dialectic nature of the individual sessions, the term refers to the patient-therapist dialogue directed at reconciling the polarized opposite feelings and attitudes of the patient, with the goal of achieving a synthesis (27). This involves the same kind of psychic integration and development of more appropriate behavior patterns, that are sought as goals in the psychodynamic therapies. Since many BPD patients had been abused and mishandled in childhood, in situations where the parents used intimidation and denial to paper over the reality of what was being done to their children, *validation* during the therapy becomes an important healing intervention: reassuring the borderline patient that certain negative experiences (neglect, unjustified punishment, incest...) really did happen, and that the patient was not "crazy" for thinking so. This intervention is often a crucial ingredient in the overall approach of DBT.

The supportive psychotherapies

Although Arnold Winston et al have expressed the view that supportive therapy is the "shell that fits over most theoretical orientations" (29), the literature on supportive therapy in relation to BPD is sparse. Appelbaum and Levy (30) have written on the application of supportive therapy to the treatment of BPD, in what becomes an amalgam of dynamic and supportive interventions of the sort earlier outlined by Rockland (31). Rockland mentioned such techniques as sympathetic listening, education, encouragement, limit setting, exhortation (to do or to refrain from certain behaviors), reassurance, advice, and validation. Appelbaum has been developing a manual of supportive psychotherapy for BPD, which will supplement those already published for TFP and DBT. Transference feelings are recognized in the supportive approaches, but transference interpretations are not used.

SHORT-TERM *VERSUS* LONG-TERM PROSPECTS

Many of the recent follow-up reports concerning BPD patients have centered on the issue of self-damaging or parasuicidal acts. Linehan et al (32) showed, for example, that BPD patients treated with DBT showed less likelihood to commit such acts by the end of a year's therapy, as compared with patients offered "treatment as usual". The latter involved fewer hours of therapy per week than DBT, so it is difficult to know how much improvement the DBT-treated patients owed to the method *per se*, as opposed to the greater time spent with each of them. In the last few years, other approaches have in any case achieved comparable results (reduction of self-harm after a year's therapy). This has been demonstrated for TFP (33) and for Peter Tyrer's manual-assisted cognitive behavior therapy (MACT) (34). These studies, taken in the aggregate, suggest that well-planned time-intensive therapy, carried out by skilled therapists using a variety of approaches, can achieve rewarding results with some of the symptomatic aspects of BPD (i.e., those that center on self-damaging acts), and can do so within the first year of therapy.

Although the new manuals focus on the first year to year-and-a-half, psychotherapy with borderline patients is a much longer enterprise. This is because one must aim not merely at the reduction of self-damaging acts and other troubling symptoms (such as depression, eating disorders, panic, dissociation and the like), but at improvement in the borderline patient's ability to function in work, at developing and maintaining friendships and, if possible, at fostering some measure of success in intimate relationships. These goals will seldom be met short of five or ten years of therapy, and long-term (10 years or more) follow-up studies are necessary to appraise the results of psychotherapy.

A HIERARCHY OF TASKS IN THE MANAGEMENT OF BORDERLINE PATIENTS

Strictly speaking, the term management, in relation to psychiatric treatment, conveys the notion of establishing a set of remedies for fairly acute or severe disorders. One "manages" acute symptoms, whereas one applies psychotherapeutic principles to the amelioration of maladaptive personality traits. Since BPD represents an agglomeration of symptoms and maladaptive traits, and often is heralded by serious or even life-threatening symptoms, management issues may dominate the scene at the outset, even as the verbal psychotherapy *per se* is getting underway. Gradually, psychotherapeutic issues come to dominate the scene, as the symptom aspects subside and become less disruptive.

A number of prominent clinicians who deal extensively with borderline patients, such as Kernberg and Linehan, have outlined hierarchies of tasks with which the therapist will be confronted as the work unfolds. Given the nature of BPD and the similarities between one large group of borderline patients and another, these hierarchies are quite similar. They will consist of a series of tasks, well-ordered as to their urgency, creating in this way a list of problems that therapists should pay attention to as they go about treating a borderline patient. Here is one convenient arrangement of these therapeutic tasks:

1. Make sure suicidality (in whatever form(s): ideation, threats, gestures, attempts) is explored and adequately dealt with.
2. Deal promptly with the patient's threat to interrupt treatment prematurely.
3. Inquire about and treat any severe non-suicidal symptoms (e.g., panic, anorexia, dissociation, depression or hypomania, substance abuse, compulsions).
4. Be alert to any signs of gross withholding of important information or any signs of dishonesty, or of antisocial tendencies.
5. If the foregoing tasks are taken care of, attend to less disruptive symptoms that may be present (e.g., social anxiety, mild depression).
6. Focus on personality traits that cause significant trouble at work or in interpersonal relationships (hostility, abrasiveness, bitterness, jealousy, manipulativeness, demandingness...).
7. Focus on less disruptive personality traits, including those that are more troublesome to the patient than to others (shyness, "moral masochism", obsequiousness, unassertiveness...).
8. Focus on long-range occupational, educational (if pertinent), and interpersonal goals; appropriateness of partner choices, and attitudes toward family members.

In this hierarchical schema, management relates primarily to steps 1 through 5. Borderline patients who improve and progress toward the latter steps are generally the ones who evolve into persons who no longer meet DSM criteria for BPD (35,36). These are the borderline patients whose therapy takes on more and more the qualities of psychotherapy with those better-functioning patients who were called psychoneurotic in the older literature and whose personality disorder would now be better characterized with a milder label, such as one of the cluster C (anxious cluster) disorders.

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SPECIAL ARTICLE

Destigmatizing day-to-day practices: what developed countries can learn from developing countries

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The nature of and threshold for stigma associated with mental disorders appears to be different between developed and developing countries. Decreasing stigma can be achieved through a combination of the best Western educational and media strategies and the systematization of some important lessons from developing countries. At the macro-level, this involves: societal changes leading to being more inclusive and re-integrating people with mental illness into our communities; finding socially useful and culturally valued work roles for such marginalized people; re-extending our kinship networks, and re-valuing contact with people with mental illness and learning from their experiences. At the micro-level, this involves developing more destigmatizing day-to-day clinical practices, including: more holistic appraisal of disorder, abilities and needs; therapeutic optimism; a strengths orientation; engaging family and redeveloping an extended support network; celebration of age appropriate rites of passage; invoking the language of recovery; valuing veterans of mental illness as "spirit guides"; promoting consumers' community living as full citizens; engaging and involving the local community in taking responsibility for their own mental health.

Key words: Stigma, developed countries, developing countries, mental health literacy, destigmatizing practices, recovery, strengths orientation, therapeutic optimism

The WPA has embarked over the last several years on a programme to challenge stigma associated with schizophrenia in both developed and developing countries. It is the objective of this programme to have both a common core strategy and a common resource data base. However, there is also an unusual commitment to encourage and support developing countries to utilize local knowledge and methods in generating their own culturally congenial anti-stigma initiatives.

This paper summarizes what developed countries can learn from developing countries in order to diminish stigma associated with mental disorders, elaborating on a prior study (1).

IS THE NATURE OF AND THRESHOLD FOR PSYCHIATRIC STIGMA DIFFERENT BETWEEN DEVELOPED AND DEVELOPING COUNTRIES?

Comparative studies by the World Health Organization (WHO) (2-4) have demonstrated a better long-term outcome for schizophrenia in developing countries, particularly in rural regions. These findings still generate some professional contention and disbelief, as they challenge outdated assumptions that people generally do not recover from schizophrenia and that the outcomes of Western treatments and rehabilitation must be superior. However, these results have proven to be remarkably robust, on the basis of international replications and 15 to 25 year follow-up studies (5).

Explanations for this phenomenon are still at the hypothesis level, but include: a) greater inclusion or retained social integration in the community in developing countries, so that the person maintains a role or status in the society; b) involvement in traditional healing rituals, reaffirming communal inclusion and solidarity; c) availability of a valued work role which can be adapted to a lower level of functioning; d) availability of an extended kinship or communal network, so that family tension and burden are diffused, and there is often low negatively "expressed emotion" in the family.

The parallels in Western society include evidence (6) that rates of apparent recovery from schizophrenia increase in periods of industrial "boom", when the job market expands, and decrease during industrial worldwide depressions, when the job market shrinks. Possible explanations of this phenomenon are: a) that having a job allows a person with schizophrenia to disappear from clinical attention; b) that access to regular work is a culturally valued role which promotes recovery and healing; c) that clinicians and the community perceive the possible clinical needs of a mentally ill person more benignly (i.e., with less stigma) if the individual has a regular job. Probably all three elements are at play to some extent.

The WPA Stigma Programme has identified a number of factors in the developing world which promote greater tolerance and community support for people with serious mental illness (7). These include: a) the absence of large-scale institutional care from the traditional mental health care system; b) the rural agrarian nature of the society; c) the strength of the extended family system; d) explanatory models which place the cause of the illness outside the patient; e) the fact that symptoms of psychosis are more readily reversible and outcome from schizophrenia better in the developing world.

Indeed, psychiatrists working in developing countries have often noted the low level of stigma attached to mental disorder (7). Among Formosan aboriginal tribesmen, in contrast to the Chinese in Taiwan, mental illness is free of stigma (8). Sinhalese families freely refer to psychotic family members as "pissu crazy" and show no shame about it; tuberculosis in Sri Lanka is more stigmatizing than mental illness (9). In Nigerian and Malaysian villages, the label "madman" or "crazy" is applied only to violent and highly disruptive people; others with schizophrenia are tolerated as eccentric, and may well be considered functional and marriageable (6). Moreover, as the experience of leprosy also demonstrates, public attitudes to illness can tell disabled people how to behave. This "moral map", once established, is often perpetuated for reasons having little to do with the disease itself (9). In some societies (e.g., Nigeria, Tanzania) leprosy is regarded as just another potentially debilitating illness, while in India it is highly stigmatized, leading to segregation, divorce, shunning and beggar status (9).

Biological explanations do not necessarily lead to more hopeful and less stigmatized outcomes. In some campaigns, the more solely biological treatments are promoted, the more fear and social exclusion result (10). The public often find that biological explanations for mental illness are difficult to understand and that these explanations imply that mental illness is essentially unchangeable despite the occasional effects of "miracle drugs". Educational programmes which place more emphasis on understandable causes and interventions to which the public can relate personally (e.g., understandable reactions to life events, trauma and deprivations, and interventions such as stress reduction, cognitive-behavioural and family strategies) improve perceptions of mentally ill people, particularly on the "safe-dangerous" and "predictability" dimensions (10). Such approaches arguably also allow communities to no longer feel helpless in the face of mental illness.

Luhrmann (11) shows how Western psychiatrists, while trying to destigmatize psychiatric illness by promoting its "medical" nature, have participated in the destruction of what attracted many of them to the profession in the first place: the chance to personally engage and heal. Western psychiatrists appear to have lost their souls, she argues, to the quest for the "fixable perfect brain" and the economic imperatives of the pharmaceutical industry and managed care.

WHAT CAN DEVELOPED COUNTRIES LEARN FROM DEVELOPING COUNTRIES IN GENERATING EFFECTIVE METHODS OF CHALLENGING STIGMA ASSOCIATED WITH MENTAL DISORDERS?

What can we learn from developing countries in our struggle against stigma associated with mental disorders?

We can learn not to segregate people with mental illness behind high walls or away from the community, so that we can retain knowledge and experience of living with such people in our midst. This accords with studies which demonstrate an improvement of attitudes and a lowering of stigma where communities have direct experience of meeting and living with people with mental illness, and feeling they can make a difference by helping such people (10).

We can learn to be inclusive of people with mental illness, integrating them into our communities. We can also learn to restructure our societies to find meaningful, socially useful and culturally valued roles for people with mental illness and other marginalized groups. In most instances (though not all), this means real pay for real work.

We can learn to reach out from our nuclear families and re-extend our kinship networks to share out the practical experience and stresses of caring, and to feel that "you are not alone" and should not feel that yours is a shunned or pariah household.

We can learn to listen to the content of experiences of psychosis, and assist individuals to discern, distil or explore possible real meanings which resonate for them and their loved ones in these experiences. Accordingly, an episode of mental illness may not just be seen as a terrible life disruption or waste of time, but as an existentially useful crisis or turning point in their lives (13). They may then resolve to live differently in terms of drug intake, stress management and co-operation with treatment.

We can learn that stigma associated with mental disorders is not fixed, indelible or universal, but is culturally applied. Therefore it is not immutable, and it is worth struggling to find culturally congenial ways of challenging it. Australia's Aboriginal people and New Zealand's Maori people with mental illness have had to contend with "double-whammy" stigmatizing and discrimination, due to dispossession and devaluing as indigenes by white society, as well as being colonized and controlled by mental health services (13). We have generally provided culturally inappropriate aversive, devaluing, spirit-breaking and poorly accessible care, with recent exceptions (13). We may well contribute to better outcomes by the direct consulting of such consumers and their families for their perceptions of care, as well as incorporating traditional cultural healing practices and/or reconciling our interventions to them.

Decreasing stigma associated with mental disorders can be achieved through a combination of the best of Western educational and media strategies and honouring, amplifying and systematizing important lessons from developing countries. This may include wider communal involvement in addressing external (psycho-social-cultural) causal or precipitating factors (e.g., losses, lack of meaningful role, spiritual crises) rather than just relying on internal biological explanations and treatments.

DESTIGMATIZING DAY-TO-DAY PRACTICES

Destigmatizing principles guiding day-to-day practice can be derived from developing countries, and combined with evidence-based interventions from developed countries. A preliminary, fairly speculative and incomplete list of such practices is summarized in Table 1.

In terms of holistic assessment, Engel's (14) bio-psycho-

Table 1 What developed countries can learn from developing countries to destigmatize day-to-day practices

- Assessing and reviewing the whole person, employing the bio-psycho-socio-cultural-spiritual paradigm *rather than* assessing and reviewing a purely biological disease, treating disembodied symptoms, intervening on fragmentary biological sub-systems.
- Externalizing symptoms and joining to challenge them *rather than* internalizing symptoms and impairments.
- More focus on consumer's role restoration, strengths, abilities. Defocus on patient's role dysfunction, weaknesses, disabilities.
- Engaging and involving consumer's immediate family, extended kinship network, proxy family and/or socio-cultural network, in a context of confidentiality and privacy rights *rather than* performing "parentectomy" or dismissing family as "toxic", denying access by family to treatment team, deciding who "the patient" should mix with.
- Orienting services towards progression through and celebration of age-appropriate rites of passage *rather than* "maintenance" programmes, retaining in a timeless limbo of often hostile dependency.
- Encouraging the re-claiming of the authorship of one's own story in more empowering and hopeful terms, and the language of recovery, potential continual growth, and expectation of improvement. Challenging the objectifying and alienating assumption that "your case notes define you" and the self-fulfilling prophecy of poor outcome embedded in the language of chronicity.
- Valuing veterans of mental illness as spirit guides and consumer consultants *rather than* devaluing them as perpetual dependents and life-long patients.
- Promoting healing and recovery by community living as a full citizen, culturally valued (work) role, and "in vivo" rehabilitation *rather than* institutional warehousing, play-work or just minding, and "in vitro" rehabilitation in artificial environments.
- Working by consumers' sense of time, sense of readiness to take the next step or leap, or "woodshedding" (non-linear tacit mode of change) *rather than* by service providers' "clock", sense of impatience or resignation, or linear predictable sense of change.
- Invoking consumer's sense of agency and control, self-determination and choice from a range of interventions, and therapeutic optimism *rather than* professional control and colonization, "vocational ownership" (we know what is best for you), and therapeutic pessimism.
- Engaging and involving the local community in taking responsibility for their own mental health (e.g., by local action groups or teams) *rather than* leaving it to authorities and mass-media campaigns, allowing the belief that "it is about them, not us".
- Teaching mental health literacy to the community and health professionals, and challenging stigma *rather than* tolerating communal and professional ignorance, media stereotyping, discrimination and stigma.

social model could be expanded into a bio-psycho-socio-cultural model to encompass cultural dimensions, including the micro-culture of family or kinship, and the macro-culture of communal perceptions, including stigma and consequent discrimination. Arguably, the spiritual domain fits within the cultural dimension with both micro-personal and macro-communal mindsets and expressions. No clinical assessment or review of an apparently delusional or deeply distressed person should be deemed complete without direct and (if possible) collateral inquiry regarding these factors.

A holistic conception of mental health involves not just the absence or overcoming of mental illness, but addressing all the qualitative dimensions of well-being, including optimizing physical health, engagement with family and social networks, and meaningful roles within one's community. Rebuilding whole lives underpins recovery. This entails mobilizing not only external expertise, but also local community knowledge, inclusion and participation.

"Externalizing" of symptoms is a principle promoted by narrative therapists (15) to challenge the traditional clinical metaphor, which can lead you to internalize your symptoms and impairment. Rather than inadvertently being inducted into the belief that you are a bunch of symptoms and an impaired or indelibly flawed person, "externalization" strategies help you to objectify the problem and think of it as separate to your identity. The symptom or diagnosis no longer defines you, and it becomes just another obstacle to your life, which you, your family and the clinician can join in challenging and overcoming.

A "strengths" and "abilities" orientation rather than the usual clinical focus on symptoms, impairments and disabilities as "weaknesses" allows you to see and value the positive qualities of this particular person. Bringing such strengths to their attention allows them to use sustained ability components to compensate for or overcome disability components of their condition. This rationale has been codified for such use in the Life Skills Profile (16), a functional ability/disability outcome measure, which scores in the direction of strengths. Therefore ratings charts (e.g., histograms) can be readily shared with clientele and families to both monitor and encourage recovery. Rapp (17) has developed a strengths orientation model for case management, which can be made compatible with the fidelity criteria for assertive community treatment teams.

Re-instilling hope for a sense of growth throughout life entails regaining or relearning the long-eroded cultural resource or tool of knowing how to progress through and celebrate age-appropriate rites of passage. With loss of communal guidance through rites of passage or life transitions, these have become buffeting and stressful and potential points of breakdown, while families may remain stuck in life, e.g., as perpetually dependent offspring of ageing parents. Meanwhile "chronic" patients remain in a timeless limbo of backward custodial care, backstreet neglect, or "maintenance stream" rehabilitation adult-minding programmes (13).

Recovery work re-emphasizes for severely mentally ill individuals the life-enhancing potential of story-telling and of reclaiming authorship for their lives. By learning how to retell their story in more hopeful and empowering terms than the dominant story in the clinical file, service users and families can choose a destiny other than one which perpetually lives out a psychiatric career (18).

"Woodshedding" (19,20) encapsulates how initial improvement following an episode of psychiatric disorder may apparently halt for frustratingly long periods. In such a seemingly static phase, the person may be busily processing internally, may be valuably acquiring subtle increments of self-esteem, competence, stamina, and social skills. Perhaps better regarded as a regulatory mechanism, the recovering person may need this period to muster sufficient strength to overcome the next hurdle, e.g., demands of a new job or leaving the hospital or parental home.

Strauss' detailed observational studies leading to the construct of "woodshedding" provide a rationale for attending to and respecting a person's readiness or preparedness for significant or even radical changes. Readiness may not fit the service provider's timetable or imposed clinical "clock" of goal attainment. The service user's timeframe of readiness to change must take preference (21).

"Therapeutic optimism" invokes a mindset which acknowledges evidence of far greater recovery from schizophrenia than hitherto considered possible, even without special intervention. These more favourable prospects are further enhanced by cognitive-behavioural strategies and by optimizing both family and communal inclusion and expectations, as well as other cultural factors associated with better prognosis and reducing stigma. "Therapeutic optimism" has an evidence base, and relevant skills can be learned, taught and operationalized, as demonstrated in programmes of early intervention in psychosis (22). Developing and nurturing local action groups, committees or teams has been the method used by the WPA Stigma Programme (23) to mobilize local participation expertise and knowledge to enhance communal mental health literacy and challenge stigma.

CONCLUSION

If public attitudes can tell people how to behave, providing them a moral map of how to be ill, then we can contribute as service providers to a moral map pointing to how to recover, how to overcome obstacles in life such as mental illness, and to share our common aspiration and life expectation of being able to retain full membership of our community while continuing to learn, develop and grow in life.

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Mental health consequences of war: a brief review of research findings

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Among the consequences of war, the impact on the mental health of the civilian population is one of the most significant. Studies of the general population show a definite increase in the incidence and prevalence of mental disorders. Women are more affected than men. Other vulnerable groups are children, the elderly and the disabled. Prevalence rates are associated with the degree of trauma, and the availability of physical and emotional support. The use of cultural and religious coping strategies is frequent in developing countries.

Key words: War, mental health, vulnerable groups, coping strategies

The year 2005 is significant in understanding the relationship between war and mental health. This is the 30th anniversary of the end of the Vietnam war and of the start of the war in Lebanon. Every day the media bring the horrors of the ongoing "war" situation in Iraq. Some recent quotations from the media depict the impact of war on mental health: "We are living in a state of constant fear" (in Iraq); "War takes a toll on Iraqi mental health"; "War trauma leaves physical mark"; "War is hell… it has an impact on the people who take part that never heals"; "War is terrible and beyond the understanding and experience of most people"; "A generation has grown up knowing only war".

Wars have had an important part in psychiatric history in a number of ways. It was the psychological impact of the world wars in the form of shell shock that supported the effectiveness of psychological interventions during the first half of the 20th century. It was the recognition of a proportion of the population not suitable for army recruitment during the Second World War that spurred the setting up of the National Institute of Mental Health in USA. The differences in the presentation of the psychological symptoms among the officers and the soldiers opened up new ways of understanding the psychiatric reactions to stress.

During the last year, a large number of books and documents have addressed the effects of war on mental health. They include the WPA book "Disasters and mental health" (1); the World Bank report "Mental health and conflicts – Conceptual framework and approaches" (2); the United Nations (UN) book "Trauma interventions in war and peace: prevention, practice and policy" (3); the United Nations Children's Fund (UNICEF) document "The state of the world's children – Childhood under threat" (4); the book "Trauma and the role of mental health in post-conflict recovery" (5) and a chapter on "War and mental health in Africa" in the WPA book "Essentials of clinical psychiatry for sub-Saharan Africa" (6).

Though there have not been any world wars since the Second World War, there have been wars and conflicts throughout the last 60 years. For example, in the 22 countries of the Eastern Mediterranean region of the World Health Organization (WHO), over 80% of the population either is in a conflict situation or has experienced such a situation in the last quarter of century (7).

War has a catastrophic effect on the health and well being of nations. Studies have shown that conflict situations cause more mortality and disability than any major disease. War destroys communities and families and often disrupts the development of the social and economic fabric of nations. The effects of war include long-term physical and psychological harm to children and adults, as well as reduction in material and human capital. Death as a result of wars is simply the "tip of the iceberg". Other consequences, besides death, are not well documented. They include endemic poverty, malnutrition, disability, economic/social decline and psychosocial illness, to mention only a few. Only through a greater understanding of conflicts and the myriad of mental health problems that arise from them, coherent and effective strategies for dealing with such problems can be developed.

The importance that the WHO attributes to dealing with the psychological traumas of war was highlighted by the resolution of the World Health Assembly in May 2005, which urged member states "to strengthen action to protect children from and in armed conflict" and the resolution of the WHO Executive Board in January 2005, which urged "support for implementation of programmes to repair the psychological damage of war, conflict and natural disasters" (8).

The WHO estimated that, in the situations of armed conflicts throughout the world, "10% of the people who experience traumatic events will have serious mental health problems and another 10% will develop behavior that will hinder their ability to function effectively. The most common conditions are depression, anxiety and psychosomatic problems such as insomnia, or back and stomach aches" (9).

This paper briefly reviews the evidence from published literature about the impact of war on the mental health of the general population, the refugees, the soldiers and specific vulnerable groups. For the purpose of this paper, the term "war" is used to include both wars waged between countries (e.g., the Iraq-Kuwait war) and conflicts within countries (e.g., Sri Lanka). The review presents data concerning some major wars/conflicts (the countries involved are considered in alphabetic order) and then briefly outlines the risk factors emerging from the literature.

IMPACT OF WAR ON MENTAL HEALTH

Afghanistan

More than two decades of conflict have led to widespread human suffering and population displacement in Afghanistan. Two studies from this country are significant in terms of both their scope and their findings.

The first study (10) used a national multistage, cluster, population based survey including 799 adult household members aged 15 years and above. Sixty-two percent of respondents reported experiencing at least four trauma events during the previous ten years. Symptoms of depression were found in 67.7% of respondents, symptoms of anxiety in 72.2%, and post-traumatic stress disorder (PTSD) in 42%. The disabled and women had a poorer mental health status, and there was a significant relationship between the mental health status and traumatic events. Coping strategies included religious and spiritual practices.

The second study (11), using a cross-sectional multicluster sample, was conducted in the Nangarhar province of Afghanistan, to estimate the prevalence of psychiatric symptoms, identify resources used for emotional support and risk factors, and assess the present coverage of basic needs. About 1011 respondents aged 15 years and above formed the sample. Nearly half of the population had experienced traumatic events. Symptoms of depression were observed in 38.5% of respondents, symptoms of anxiety in 51.8% and PTSD in 20.4%. High rates of symptoms were associated with higher numbers of traumatic events experienced. Women had higher rates than men. The main sources of emotional support were religion and family.

The Balkans

The conflict in the Balkans is probably one of the most widely studied (12-14) in recent years. Mental health of survivors of both sides was examined (15).

An initial study (16) among Bosnian refugees demonstrated an association between psychiatric disorders (depression and PTSD) and disability. A three-year follow-up study on the same group concluded that former Bosnian refugees who remained living in the region continued to exhibit psychiatric disorders and disability after initial assessment (17).

A cross-sectional cluster sample survey among Kosovar Albanians aged 15 years or older found that 17.1% (95% CI 13.2%-21.0%) reported symptoms of PTSD (18). There was a significant linear decrease in mental health status and social functioning with increasing amount of traumatic events in those aged 65 years or older, and with previous psychiatric illnesses or chronic health conditions. Internally displaced people were at increased risk of psychiatric morbidity. Men (89%) and women (90%) expressed strong feelings of hatred towards the Serbs, with 44% of men and 33% of women stating that they would act on these feelings.

In a study of the mental health and nutritional status among the Serbian ethnic minority in Kosovo, the General Health Questionnaire (GHQ)-28 scores in the subcategories of social dysfunction and severe depression were high, with women and those living alone or in small family units being more prone to psychiatric morbidity (19). In a community sample of 2,796 children aged between 9 and 14 years, high levels of post-traumatic symptoms and grief symptoms were reported (20). This was related to the amount and type of exposure. Girls reported more distress than boys.

Cambodia

Cambodia has had a long history of violence, highlighted by the civil war in the 1960s, culminating with the "Khmer Rouge" rule that destroyed the social fabric of the society. Studies have found that refugees had high levels of psychiatric symptomatology after 10 years (21).

A household survey of 993 adults from Site 2, the largest Cambodian displaced-persons camp on the Thailand-Cambodia border, found that more than 80% felt depressed and had a number of somatic complaints despite good access to medical services (22). Approximately 55% and 15% had symptom scores that correlated with Western criteria for depression and PTSD, respectively. However, despite high reported levels of trauma and symptoms, social and work functioning were well preserved in the majority of respondents. Cumulative trauma continued to affect psychiatric symptom levels a decade after the original trauma events (23). This study also reported that there was support for the diagnostic validity of PTSD criteria, with the notable exception of avoidance. The inclusion of dissociative symptoms increased the cultural sensitivity of PTSD. Psychiatric history and current physical illness were found to be risk factors for PTSD (24).

Changes in the structure of the society have led to a breakdown of the existing protective networks such as the village chief and the elders in the village, especially for women (25). Traditional healers (monks, mediums, traditional birth attendants), who played an important role in maintaining the mental health of communities in the past, have lost their designated positions in the community following the conflict (26).

Twenty-seven Cambodian young people, who were severely traumatized at ages 8 to 12, were followed up 3 years after a baseline evaluation. A structured interview and self-rating scales showed that PTSD was still highly prevalent (48%) and that depression was present in 41% (27).

Chechnya

The human rights abuses in the Chechen population have been well documented (28). A report on a small number of Chechen asylum seekers in the UK adds to the evidence on the abuses and related psychological fallouts (29). Psychosocial issues were explored in a survey conducted in settlements housing displaced people (n=256) (30,31). Two thirds of respondents agreed with the statement that the conflict has triggered mental disturbance or feelings of being upset. Nearly all respondents indicated that they had family members having difficulty in coping with their disturbance or upset feelings. Coping strategies used were praying, talking, keeping busy, and seeking the support of family members.

Iraq

Iraq has been at war at numerous times in history: a series of coups in the 1960s, the Iran-Iraq war (1980-1988), the anti-Kurdish Al-Anfal campaign within the country (1986-1989), the Iraqi invasion of Kuwait resulting in the Gulf war (1991), and the conflict starting in 2003. The UN-imposed economic sanctions following the Gulf war have had a profound impact on the health of Iraqis. The human rights abuses have also been recorded (32).

There are few studies on the impact of these conflicts on mental health. A study on 45 Kurdish families in two camps reported that PTSD was present in 87% of children and 60% of their caregivers (33). A study on 84 Iraqi male refugees found that poor social support was a stronger predictor of depressive morbidity than trauma factors (34). During the last three years of occupation by foreign forces, there have been many news reports about the mental health of the population, but no systematic study.

Israel

Israel has been in a situation of conflict for over four decades. A large number of systematic studies have been undertaken in different population groups. A recent study (35) found that 76.7% of subjects exposed to war-related trauma had at least one traumatic stress-related symptom, while 9.4% met the criteria for acute stress disorder. The most common coping mechanisms were active information search about loved ones and social support. Another study (36) reported that, twenty years after the war with Lebanon, an initial combat stress reaction, PTSD-related chronic diseases and physical symptoms were associated with a greater engagement in risk behaviours.

Lebanon

Lebanon has been ravaged by a civil war (1975-1990) and by an Israeli invasion in 1978 and 1982. The mental health impact of these conflicts has been studied extensively.

A random sample of 658 people aged between 18 and 65 years was randomly selected from four Lebanese communities exposed to war (37). The lifetime prevalence of DSM-III-R major depression varied across the communities from 16.3% to 41.9%. Exposure to war and a prior history of major depression were the main predictors for current depression.

The correlation between mother's distress and child's mental health was explored in a study in Beirut (38). The level of perceived negative impact of war-related events was found to be strongly associated with higher levels of depressive symptomatology among mothers. The level of depressive symptomatology in the mother was found to be the best predictor of her child's reported morbidity. In a study carried out in 224 Lebanese children (10-16 years), the number of traumatic experiences related to war was positively correlated to PTSD symptoms, with various types of war traumas being differentially related to the symptoms (39).

A cross-sectional study conducted among 118 Lebanese hostages of war (40) found that psychological distress was present in 42.1% of the sample compared to 27.8% among the control group. Significant predictors for distress were years of education and increase in religiosity after release.

Palestine

During the last decade a large number of studies have reported high levels of psychosocial problems among children and adolescents, women, refugees and prisoners in Palestine.

A study conducted by the Gaza Community Mental Health Programme among children aged 10-19 years (41) revealed that 32.7% suffered from PTSD symptoms requiring psychological intervention, 49.2% from moderate PTSD symptoms, 15.6% from mild PTSD symptoms, and only 2.5% had no symptoms. Boys had higher rates (58%) than girls (42%), and children living in camps suffered more than children living in towns (84.1% and 15.8% respectively).

A study on Palestinian perceptions of their living conditions during the Second Intifada (42) found that 46% of parents reported aggressive behaviour among their children, 38% noted bad school results, 27% reported bed wetting, while 39% stated that their children suffered from nightmares. The study also revealed that more refugee (53%) than non-refugee (41%) children behaved aggressively. Thirty-eight percent of the respondents said that shooting was the main influence, 34% stated that it was violence on TV, 7% cited confinement at home and 11% reported that it was the arrest and beating of relatives and neighbours. Seventy percent of refugees and non-refugees stated that they had not received any psychological support for the problems of their children.

In a series of studies during the last 10 years from the Gaza Community Mental Health Centre (43), the most prevalent types of trauma exposure for children were witnessing funerals (95%), witness to shooting (83%), seeing injured or dead strangers (67%) and family member injured or killed (62%). Among children living in the area of bombardments, 54% suffered from severe, 33.5% from moderate and 11% from mild or doubtful levels of PTSD. Girls were more vulnerable.

Rwanda

The physical and mental health problems of the survivors of the genocide in Rwanda have been well documented (44). In a recent community based study examining 2091 subjects (45), 24.8% met symptom criteria for PTSD, with the adjusted odds ratio of meeting PTSD symptom criteria for each additional traumatic event being 1.43. Respondents who met PTSD criteria were less likely to have positive attitudes towards the Rwandan national trials, suggesting that the effects of trauma need to be considered if reconciliation has to be successful. There have been reports on the state of health among the large numbers of refugees (500,000-800,000 in five days) who fled to Goma, Zaire following the capture of the capital Kigali, but none of them has considered the mental health dimension.

Sri Lanka

The conflict between the majority Sinhala and minority Tamil population in Sri Lanka has been ongoing for nearly 30 years. One of the first studies that looked into the psychological effects of the conflict on the civilian population was an epidemiological survey (46), which reported that only 6% of the study population had not experienced any war stresses. Psychosocial sequelae were seen in 64% of the population, including somatization (41%), PTSD (27%), anxiety disorder (26%), major depression (25%), alcohol and drug misuse (15%), and functional disability (18%). The breakdown of the Tamil society led to women taking on more responsibilities, which in turn made them more vulnerable to stress (47). Children and adolescents had higher mental health morbidity (48).

Somalia

A study carried out in ex-combatants in Somalia found high psychiatric morbidity and use of khat (49). A UNICEF study found evidence of psychological effects of the prolonged conflict situation in a high proportion of a sample of 10,000 children (50). There is near total disruption of the mental health services in the country.

Uganda

Sudanese refugees fled into northern Uganda in two major waves in 1988 and 1994. Symptoms of PTSD and depression were found to be highly prevalent among Sudanese children living in the refugee camps (51). Refugees had higher rates of individual psychopathology than the general population, and it was observed that the cumulative stress grew as the years in exile progressed. The consequences of long-term exile were still present 5-15 years later, with an increase in the rates of suicide and alcohol use.

RISK FACTORS

From the large amount of studies reviewed, some broad risk factors and associations can be drawn.

Women have an increased vulnerability to the psychological consequences of war. There is evidence of a high correlation between mothers' and children's distress in a war situation. It is now known that maternal depression in the prenatal and postnatal period predicts poorer growth in a community-based sample of infants. Social support and traditional birth attendants have a major role in promoting maternal psychosocial well being in war-affected regions. The association between gender-based violence and common mental disorders is well known. Despite their vulnerability, women's resilience under stress and its role in sustaining their families has been recognized.

There is consistent evidence of higher rates of trauma-related psychological problems in children. The most impressive reports are those from Palestine. Of the different age groups, the most vulnerable are the adolescents.

The direct correlation between the degree of trauma and the amount of the psychological problems is consistent across a number of studies. The greater the exposure to trauma – both physical and psychological – the more pronounced are the symptoms.

Subsequent life events and their association with the occurrence of psychiatric problems have important implications for fast and complete rehabilitation as a way of minimizing the ill effects of the conflict situations.

Studies are consistent in showing the value of both physical support and psychological support in minimizing the effects of war-related traumas, as well as the role of religion and cultural practices as ways of coping with the conflict situations.

CONCLUSIONS

The occurrence of a wide variety of psychological symptoms and syndromes in the populations in conflict situations is widely documented by available research. However, research also provides evidence about the resilience of more than half of the population in the face of the worst trauma in war situations. There is no doubt that the populations in war and conflict situations should receive mental health care as part of the total relief, rehabilitation and reconstruction processes. As happened in the first half of the 20th century, when war gave a big push to the developing concepts of mental health, the study of the psychological consequences of the wars of the current century could add new understandings and solutions to mental health problems of general populations.

A number of issues have emerged from the extensive literature on the prevalence and pattern of mental health effects of war and conflict situations. Are the psychological effects and their manifestation universal? What should be the definition of a case requiring intervention? How should psychological effects be measured? What is the long-term course of stress-related symptoms and syndromes? (52). All these issues need to be addressed by future studies.

It is important to report that the WHO and some other UN-related bodies have recently created a task force to develop "mental health and psychosocial support in emergency settings" (53-55), which is expected to complete its activity in one year.

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The population health argument against war

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There is ample evidence of a high prevalence of psychopathology among those persons unlucky enough to have lived through war, either as combatants, or, and even more so, as civilians caught in the middle of larger conflicts (1-3). Murthy and Lakshminarayana's article summarizes this evidence cogently and also shows that persons who are socially or economically vulnerable, including children, the elderly, and in many cases women, are more susceptible to the mental health consequences of war, and that ongoing displacement, stressors, or traumas may prolong the course of psychopathology and delay recovery. Although this review focuses on psychopathology, we should not forget that war is also accompanied by substantial mortality and physical morbidity, and, importantly, that there is a strong interrelationship between physical and psychological morbidity: persons who are physically injured are more likely to have prolonged psychopathology (4,5), and conversely, mental illness or injury increases the likelihood of poor physical health (6).

War is a display of force intended to subjugate one group to the will of another. It is perhaps then one of the primary goals of war to inflict harm (physical and psychological) as a means of forcing surrender and a cessation of activities undesirable to the warring party. Although war has long been part of human history and experience, a recent resurgence in between-nation conflict has resulted in substantial political discussion about "just" wars, or wars that are acceptable (7-9). These arguments suggest that war, while potentially having adverse consequences for those involved, is justifiable based on the alternatives. We suggest, however, that the burgeoning evidence documenting the mental and physical health consequences of war, among combatant and noncombatant populations alike, is seldom considered in the calculus leading up to decisions being made about war and its acceptability. Further, consideration of the full scope of the population health consequences of war raises the bar substantially about the conditions under which war is truly justifiable and as such provides a powerful argument against the initiation or perpetration of large-scale conflict.

One of the myths of modern warmaking is that wars can be conducted in a targeted "smart" way, focusing hostilities on armed combatants or political leaders without injuring the population. However, the evidence suggests that it is virtually impossible to conduct war in a way that targets only those who might be fighting back or those responsible for political and military decisions (10,11). The consequences of war inevitably include the deterioration of existing social structures, expose populations to stress and trauma, limit population access to preventive and curative health, and result in elevated rates of psychopathology and physical morbidity in persons who may well not be the intended targets of the conflict. In the vast majority of circumstances, poor population health is an inevitable consequence of war. We would suggest that arguments for just wars need to balance the adverse consequences an intended war will likely have on population health with the ongoing damage to population health in the absence of war.

Although we focus here on population health as an end in and of itself, it is the centrality of health to the achievement of other ends throughout life that in many ways cements the population health argument against war. Health is the underlying precondition for persons to achieve their personal goals and, by extension, achievement of societal goals is predicated on population health. Therefore, through limiting the health of populations, war is effectively limiting the achievement of these populations on all other conceivable fronts. This argues for an appreciation of the fact that the impact of war on societies lingers far after the war itself. Psychological and physical pathology persist for many years after war may have ended and so does the impact of any given war. Unfortunately, our appreciation of a time frame beyond a few years is limited, a limitation that is reinforced by the ever-more-pervasive news media that quickly moves on to the next story once a war is "over". However, war is seldom "over" within any given generation. The health consequences of war persist, and as a result, so do the social and economic consequences that shape all other experiences for a generation that has lived through a war. Perhaps even more alarming, recent studies suggest the inter-generational transmission of psychological trauma (12,13), further reinforcing the pervasive and long-term impact of war.

There is an abundance of accumulating empiric evidence about the social and economic consequences of adverse health. Most obviously adverse health burdens health care systems with a greater volume of need and with the attendant economic costs of providing care to those with psychological or physical morbidity. However, the indirect costs of adverse health are just as important and frequently overlooked. Adverse health is associated with limited productivity, decreased engagement in societal activities, and the imposition of a burden of care-giving on informal, as well as formal, social networks and services (14). The sum total of these costs is difficult to estimate, and is seldom considered, but these costs clearly go far beyond the costs of healthcare or of public health services. Therefore, the economic burden to societies, compounded by the impact of war on population health, must be considered as one of the consequences of war in any calculus about the "justness" or acceptability of any war.

Both overt inter-nation armed conflict as well as more limited wars such as long-term low-intensity conflict are associated with poor mental and physical health in the short and in the long term. The effect of this increased pathology is pervasive and persistent in the population and has far-reaching social and economic implications for societies at war. Those responsible for public health need to insist that the population health consequences of war are clearly articulated and considered as part of any calculus or public debate about the initiation of war.

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How to prevent turning trauma into a disaster?

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There are many reasons why war does not do good to mankind. Amidst them are mental health consequences. Murthy and Lakshminarayana review studies that demonstrate the psychological impact of hostilities, stress and exposure to shocking events. The message is twofold. War may cause significant and pervasive psychopathology in civilians. At the same time, the majority of people in the theatre are rather resilient. Notwithstanding the war situation, they do not develop problems such as post-traumatic stress disorder (PTSD), anxiety or depression.

This is also seen in military personnel who are deployed in overseas peacekeeping operations. The vast majority of soldiers return home safe and healthy. They are often self-contented. They were able to do the duties they were trained for, they were given an opportunity to contribute to a safer world and they often have experienced bonding with colleagues. The reverse of the medal consists of a small, but significant part of military personnel who are faced with a great diversity of health problems. About one out of every five soldiers develops post-deployment symptoms (1).

Military deployment and trauma are often bracketed together. Problematic health status in military personnel is often attributed to PTSD, not only by laymen. This is not surprising, because the concept of PTSD originates from the problematic aftermath of the Vietnam War. In 1980, PTSD was introduced as a diagnostic entity in the DSM. However, equalling PTSD and military health problems would be simplistic. About a quarter of post-deployment symptoms can be explained by PTSD, but other main concerns are medically unexplained physical symptoms, anxiety, depression and substance misuse.

In the 1990s, the need for a broader view was demonstrated in studies in Gulf War veterans. The American and British army were confronted with large groups of military servicemen, returning from the first Persian Gulf War, reporting ill health. They were dog-tired and suffered from a wide range of symptoms. In fact, these military experienced health complaints which are common in the general population. They suffered the same health problems although much more frequent as compared to civilians and military who were not sent to the Persian Gulf (2).

There was a lot of speculation on and rumour about the causes of Gulf War related illness. An unequivocal causal factor, e.g. exposure to harmful substances, has never been found. At that time, Dutch United Nations (UN) soldiers returned from deployment in Cambodia. Their health was also troublesome. Research showed that 17% of the ex-servicemen suffered from severe fatigue. PTSD was observed in less than 2% (3).

Post-deployment symptoms may be severe, persistent and chronic. They actually show striking similarities with the whether: the state of today is the strongest predictor for tomorrow's situation. A part of Gulf War and Cambodia veterans has significant complaints and is not able to get rid of them. War also leaves tracks in the long-term. Twenty-five years after deployment in Lebanon, about 15% of Dutch UN veterans still reported impaired psychological well-being (4).

Murthy and Lakshminarayana emphasize that research on the long-term course of stress-related symptoms and syndromes is needed. They are right in the sense that large scale epidemiological research on post-trauma psychopathology is relatively scarce. But the studies that have been performed yield rather unambiguous results: war impacts on humans in varying degrees.

Here we enter the field of psychosocial care, a promising area which is experiencing a growth. Evidence and best practices have been showing the value of and need for psychosocial care, although knowledge gaps exist. For example, evidence based treatment of medically unexplained physical symptoms is still lacking. Concerning early psychological interventions following trauma, we know what does not work, but we do not know what is effective.

Conflict and war may be a fact of life. There will always be trauma, distress and horror, but we can prevent turning trauma into a disaster. That is why we need to conduct research on these issues and that is why we need to invest in psychosocial care.

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Mental health consequences of war: gender specific issues

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Modern warfare targets civilian populations. We are experiencing a significant increase in the percentage of civilian deaths among those killed in a war, and up to 90% of casualties today are civilians (1). In their review, Murthy and Lakshminarayana state that "women have an increased vulnerability to the psychological consequences of war". Indeed, women and men are exposed to different traumata in times of war. They may exhibit different psychological problems, cope in different ways, and have different thresholds for entering treatment. Thus, the gender perspective is both challenging and needed.

War creates acute and long-lasting health problems in men and women, but many aspects of war affect the health of women disproportionately, through societal changes that may subordinate them and not prioritize their life and health (2). In areas of war and conflict, women are more likely to face the threats of community violence outside the home (3). As mentioned by Murthy and Lakshminarayana, women may experience violent acts, as seen in recent conflicts, including those in the Darfur region of Sudan and in Iraq.

There is increasing recognition by international organizations of the particular risks that women face in refugee camps (4,5). Women who seek shelter from the hardships of armed conflicts may end up experiencing further harassment in what, from an outside perspective, should be a safe environment (6).

Many women may in war be faced with the main responsibility for care giving in the family, with the destiny of their husbands unknown and new and unfamiliar duties placed on them. If the household is facing disaster, this may overload women's capacity to cope, as preoccupation with the needs of the family may lead to that they are not able to consider their own needs, especially if they become widows. Their means of supporting the family may be scarce and rendering sexual services may be their only way out (2). On the other hand, the care-giving role may have a protective function providing women with a natural role and identity.

Adequate medical care is seldom available in war and post-war countries. Women (as well as men and children) may suffer for years from war-induced health problems without receiving appropriate medical care (7). In some countries, as in Afghanistan, women have been prevented access to medical care (8).

Women may frequently express complaints of a somatic nature and seek help with little understanding of the psychological nature of such symptoms. Knowledge on psychotherapy may be limited and some may express a resistance to talk about psychological problems – partly because of fear of stigmatization, partly because their families may view treatment for psychological problems as non-legitimate (9).

A sustainable relation between therapist and client that will allow the client to reveal her traumatic experiences presumes that the therapist pays due attention to the woman's state of mind and current life situation, with gender discrimination or devalued status in society.

Cultural norms influence what is acceptable behaviour. Women who are refugees or live in war zones are frequently under severe social control, as they are expected to follow traditional patterns and show loyalty to old customs that may not coincide with their current situation and wishes. A widow, for example, may find that her behaviour is closely followed, whereas this is not the case for a widower, who experiences greater freedom of movement (10).

Therapists face a delicate balance between their wish to respect the values of the client's culture and their duty to empower the female client and support her more assertive sides in the post-war setting.

As therapists we have to keep in mind that most of us are trained in Western concepts and work in an individualistic society with emphasis on privacy and autonomy (11), while many women experiencing the atrocities of war come from sociocentric societies where persons characteristically are seen "as their role". Consequently, the failure to perform one's role as wife, mother, or daughter may be interpreted as a failure as a person.

Women's health situation is frequently characterized by a variety of problems caused by a combination of traumatic past and current stressors. In addition, women may be subjected to restrictions in their personal mobility and efforts to adapt to new roles, further adding to their disadvantage and marginalization (9).

Society has an obligation to develop services that offer culture and gender sensitive care paying respect to women's rights (12*)*. The fact is, however, that many women experience that services may aggravate their feeling of disempowerment, due to their focus on pathology and reduced functioning instead of promotion of health and recovery. If available services fit this description, women may find little relief when referred to care.

As therapists we should work for that women referred to treatment would encounter cultural competent staff that encourage empowerment, self-management and autonomy in daily activities (12).

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Building and translating evidence into smart policy: continuing research needs for informing post-war mental health policy

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Murthy and Lakshminarayana's review of research findings on the mental health (MH) consequences of war and armed conflict (hereafter referred to as war) provides an outline of how far the knowledge base has grown in the last 30 years, and also highlights how much further it has yet to go.

While the studies cited provide a snapshot of war's psychological impact, there is less empirical information available to guide policymaker and clinician decisions about how best to address the MH needs of individuals directly and indirectly affected by war. Such information is sorely needed, however, as the resources available to address MH needs in the aftermath of war are often limited, both in terms of adequate numbers of individuals prepared to approach MH issues and funding for MH services. As a result, difficult decisions must often be made regarding the priority of addressing MH needs during post-war reconstruction versus other priorities, including providing physical health care and services to meet public health needs, fostering economic redevelopment, maintaining security, and establishing safe and adequate housing (1). Decisions must also be made regarding what MH services should be provided, to whom they should be provided, who should be providing them, and within what time frame. While there are ethical and logistical challenges in gathering these data in the immediate aftermath of war, we will list below some of the research questions which should be addressed to ensure that scarce resources are used in a manner most likely to reduce psychiatric or psychological morbidity.

How should we identify individuals who require interventions, and when should such interventions be delivered? In the aftermath of other community-wide traumas (e.g., natural disasters, community violence, etc.), psychological or emotional symptoms often diminish over time or change in frequency, nature, and severity for many exposed individuals (2,3). In addition, symptomatic individuals are not always impaired (4). These findings, however, are from populations exposed to events that are less pervasive and traumatic than war. A better understanding of the longitudinal and developmental effects of exposure to war would improve the ability to target interventions to those individuals most in need, when they need it. Optimally meeting exposed individuals' MH needs requires careful consideration of when and how to best commit resources, and in some cases may require policymakers to weigh the pros and cons of acute interventions to address the most pressing needs vs. longer term strategies to address the broad range of persistent and impairing MH problems that may result from exposure to war.

How should we choose and implement effective interventions? Further work is needed to develop and deliver interventions that best address the MH needs of individuals exposed to war. Expert consensus groups have recommended core elements that should exist in these MH interventions (5). These include addressing the individual's trauma in the context of his family, community, and society (6), addressing cultural influences on exposed individuals experiences (7), and realizing that the appropriate interventions in the context of ongoing conflict and its immediate aftermath may differ from those in subsequent periods (5). While there is an increasing evidence base of effective interventions for traumatized individuals (8), there remains a paucity of empirical data to guide clinicians and policymakers with respect to the optimal content of interventions to be provided to individuals exposed to war.

How and where should MH services be provided if the health care system has been degraded? Clinicians and policymakers must consider how best to meet the MH needs of individuals within the environment that exists in a post-conflict community. This may be especially challenging since the capacity for MH care is often degraded during conflict (9), and in many conflict ridden or impoverished countries the system for providing MH care was often limited prior to war.

We have made tremendous progress in our understanding of the psychological impact of war on exposed individuals. The challenge of the coming decades is enhancing our ability to make more informed decisions about how to best address the psychological needs of these individuals.

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Terrorism and its effects on mental health

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"Thou shall not kill", yet wars remain conspicuously present in the world map, as noted by Murthy and Lakshminarayana in their paper. Obviously, neither it is death the sole result of wars – psychiatric morbidity and disability are among the many outcomes of armed conflicts – nor the victims are confined to the military. Civilians, who are not spared the horrors of wars, are the prime targets of the horrors of terrorism. Indeed, terrorism is a hostile activity that is primarily aimed at civilians, with the purpose of advancing a specific agenda, political or other. Sadly, terrorist attacks, more than wars, are now claiming visibility in the news headlines in most regions of the world.

Mental health researchers are exploring the effects of terrorism on the individual and on communities. While some highlight the psychopathological effects of terror (1), others focus on the human suffering, which is not synonymous of psychiatric morbidity (2), and on community and cultural factors that enable withstanding the stressful event (3). This conflict between two polar approaches (2) has yet to be bridged. While open, the conflict grants the benefit of neither leading to conclude too prematurely that direct or indirect psychiatric action is to be ruled out, nor that the sole target of the interventions is the individual. A balanced approach may be advisable. The World Health Organization (WHO) has issued guidelines for action during emergencies which seem to endorse such a stand (4).

The fact that "someone experiences or witnesses an act of violence" does not mean that he or she "will inevitably develop psychiatric morbidity" (5). After the September 11, 2001 attacks in New York City, it was noted that "in the aftermath of terrorist attacks, many Americans... regarded their distress as a 'normal' reaction" rather than "a disorder needing [psychiatric] care" (6). Bleich et al (7), in a survey conducted during intense terrorist attacks in Israel, found that post-traumatic stress disorder (PTSD) rates were unexpectedly low, 5.3%, although threats and losses were sustained by the population country-wide. An investigation on the use of services in Jerusalem during a period in which terrorism escalated, 2000-2004, found that city residents did not favor consultation with free and highly accessible psychiatric services, but instead turned to the general practitioners and the national telephone hotline for support (8).

What the currently available evidence seems to suggest is that it takes more than the agent (e.g., threat to life) to provoke psychopathology. Indeed, the role of the environment is of importance, a component of the epidemiological triangle that has been neglected by a greater focus on host-related factors (e.g., gender or age of the victim). Solomon and Laufer's study on adolescents (9), and those by Shalev et al (10), Kaplan et al (11) and Billig et al (12) on adults, have identified a group of factors, including religious beliefs, ideological commitment and social capital, that have protected communities which were highly exposed to terrorist attacks causing loss of dear ones, physical injuries and property damage. On the other hand, it is not redundant to notice that "Ideology and religious commitment also have a darker side. ...The most centered you become in your group, the less you are open to other ideologies or religious ideas. Thus ideology and religion may be used as a healing power, but also as a weapon. This is especially true in our [Middle East] region." (13).

Murthy and Lakshminarayana's paper leaves us partially hopeful that, by advancing research on the mental health effects of war-related activities, psychiatrists are joining the call by WHO member states to devise means to repair the psychopathological damage sustained by victimized populations. However, there may be other tasks for our field. Even at the risk of raising idealistic initiatives that skeptics would prefer to dismiss, one wonders whether what Murthy and Lakshminarayana have proposed is all what psychiatrists could do. There are many other possibilities open for psychiatrists who by the nature of their profession walk the path of health and peace rather than of war. Psychiatrists and other mental health professionals from countries in conflict may engage in collaboration in a number of endeavors (e.g., teaching, exchange of experiences in program development and services, communication), while they are actively, stubbornly and continuously supported by WPA. Importantly, their efforts may contribute to make their societies even more keenly aware that in armed confrontations no one is a winner but that everyone is a victim. The model of collaboration in the Balkans, where mental health is a bridge to reconciliation within the framework of the "Stability Pact", is a concrete example of what could be achieved when a unifying language is spoken, and when such an effort is buttressed by committed support from sources that are not part of the conflict.

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The tragedy of war

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The dire consequences of war, particularly for the civilian population, are only too well brought out by the survey of the psychological consequences of current conflicts by Murthy and Lakshminarayana. The nature and type of the man-made disaster called war has been changing in recent times. From direct fighting between countries for territory or conquest of land and world wars where several countries could become involved on each side, conflicts have increasingly become internal, within countries, involving ethnic and other civil groups against each other, typically "low-intensity" conflicts involving poor third world countries.

It has been estimated that there have been over 150 such wars since 1945, where 90% of all casualties were civilians. According to Bracken et al (1), what predominates is the use of terror to exert social control, if necessary by disrupting the fabric of grassroots social, economic and cultural relations. The target is often population rather than territory and psychological warfare is the central element. Atrocities, including civilian massacres, reprisals, bombing, shelling, mass displacements, disappearances and torture, are the norm. As can be expected, the consequences for mental health, not to mention the social, economic, cultural and other costs, can be substantial. The survey of studies in Afghanistan, Balkans, Cambodia, Chechnya, Iraq, Israel, Lebanon, Palestine, Rwanda, Sri Lanka, Somalia, and Uganda shows the devastating consequences.

Unfortunately, in such circumstances the resources to help those affected are extremely limited. In particular, the infrastructure of the health services can be destroyed and the availability of health staff, equipment and drugs depleted. There may be no mental health services at all (2), or they may be functioning at a very basic level.

Thus it behooves us as clinicians to look at how we can address these sequelae. Here, studies on the effectiveness of the various methods are insufficient.

Obviously, primary prevention of war itself would be best. Easier said than done! We may feel rather weak and helpless as far as decision making or finding a solution is concerned. However, health workers in areas of conflict have started emphasizing that as health professionals we cannot remain silent, we need to consider the ethics and take principled stand for victims and society (3,4). The medical profession has a powerful and persuasive voice. Particularly, if we can quietly raise one consistent voice for peace. Reports, documentation and publications are one way that the medical profession can bring pressure. Studies and surveys of the consequences of war can be very useful for advocacy and persuasion of authorities to use more peaceful methods to solve conflicts. Or, this can be in our day-to-day dealings and contacts, where we can take principled stands on issues and express our concerns, for example on such issues as landmines, child soldiers and torture. Another area of intervention, both for prevention and reconciliation, is at the national level, by influencing policy making, rehabilitation and international aid programmes. The World Health Organization (WHO) has developed the concept of using "health as a bridge for peace" (HBP). Internationally, many members of the medical profession, individually and as a group, have come out strongly against war. Medical organizations such as the World Medical Association (WMA); the Danish, Chilean and British Medical Associations, US Physicians for Human Rights, the American Public Health Association, and the South African National Medical and Dental Association (NAMDA) have clearly voiced their concern on the effects of organized violence and war.

Secondary prevention would involve the treatment of those in the population having the psychiatric disorders discussed in Murthy and Lakshminarayana's piece (5). There appears to be controversy on terminology and approaches. One fundamental issue stems from the narrow definition of mental health, which tends to delineate the psychiatric or medical end of the spectrum to the more general psychosocial problems encountered after a major calamity (6). Further, it is still not clear which methods are effective in such situations. Current practice ranges from psychological first aid and crisis intervention in the immediate aftermath to longer term psychotherapy, cognitive behaviour therapy, traditional relaxation methods, rites, rituals and traditional healing, pharmacotherapy, family and group work, and socio-economic rehabilitation. The WHO (7) has given basic guidelines for use in emergency situations. Special programmes to address the specific needs of vulnerable populations at most risk such as women, children, elderly and disabled will need to be implemented. In view of the widespread consequences affecting large numbers in the population, most authorities are agreed that community based approaches would be most appropriate (8). Psychoeducation for the general population and training of grassroot workers on simple mental health skills using manuals such as the WHO's "Mental Health of Refugees" (9) adapted to the local cultural context would be effective in ameliorating most of the basic ill effects.

When looking at tertiary prevention, psychosocial interventions integrated with rehabilitation and reconstruction efforts would be judicious. Here, recourse to the role of traditional practices, including cultural rituals and ceremonies to give meaning to what has happened, becomes important. The natural resilience of communities and coping strategies have to be encouraged and built upon. The widespread problem of collective traumatization is best approached through community level interventions. Further, community based approaches will enable one to reach a larger target population as well as undertake promotional public mental health activities at the same time. In these circumstances it may be more meaningful to look at how the community as a whole has responded, and what we can do at the collective level. For example, it may be more beneficial to consider strengthening and rebuilding the family and village structures, re-establish positive social processes, relationships and institutions. It is essential to avoid the development of dependence and "learned helplessness" found so often in displaced and refugee camps due to improper aid procedures as well as the passivity, "conspiracy of silence" and resignation due to the chronic violence. Local participation, resettlement, livelihoods, income generation, and vocational training are important to reintegrate affected populations in social and national life by helping them regain their self-confidence, esteem, dignity and motivation.

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War and mental disorders in Africa

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Many wars continue to engulf Africa, from east to west and from north to south, leaving many Africans severely traumatized (1). Musisi (2), in his chapter in the recently published volume "Essentials of clinical psychiatry for sub-Saharan Africa", reports significant physical and psychological war-related trauma inflicted to the Ugandans in their homes, at military checkpoints and in detention. The most commonly encountered mental disorders were found to be post-traumatic stress disorder (PTSD) at 39.9%, depression at 52%, anxiety at 60% and somatization disorder at 72.2%. The prevalence of suicidal behaviour was recorded as 22.7% and that of alcohol abuse as 18.2%.

These incredibly high figures for mental disorders in war-affected Ugandans are reflected by another recent study among internally displaced Kenyans following ethnic clashes in parts of the country. Njau (3) found, in this highly traumatized population, a prevalence rate of 80.2% of PTSD amongst the heads of households. Neuner et al (4) studied a random sample of 3,339 refugees in the west Nile region, including Ugandans and Sudanese, and found that 31.6% of the male and 40.1% of the female respondents fulfilled the criteria for a DSM-IV PTSD diagnosis. He also found a near linear rise of psychological strain with the increasing number of traumatic events, ranging from a 23% prevalence of PTSD in those who reported three or fewer pre-defined traumatizing experiences to a 100% prevalence in those who reported 28 or more traumatic events. In a recent study, Pham et al (5) found that, among the 2091 participants who survived the 1994 genocide in Rwanda, 24.8% met the symptom criteria for PTSD.

All these studies support the fact of the existence of recognizable PTSD within African populations. This reality, however, is in contrast to that held by some experts (6) who state that PTSD in Africa is a pseudo-diagnosis by Western agencies who medicalize understandable social consequences of war and who bring about Western models of management that are inappropriate. It is precisely this type of misconception that sets Africa aside and apart from the rest of the world when it comes to the conceptualization of PTSD. There is ample evidence in support of the fact that Western conceptualizations of PTSD have validity in Africans, and that war survivors in Africa can and do show symptoms of PTSD (7-9).

It is expected that this Forum will stimulate thinking and action not only among African academics but also among aid agencies. These ought to wake up to the reality that the prevalence of mental disorders in Africa is likely to be extremely high, as a direct result of the wars that have caused many to lead lives as refugees.

While attention of the Africans and the world have (correctly) in the last few decades focused on infectious diseases including HIV/AIDS, it would seem reasonable to now accept that mental health consequences of war and displacement are contributing significantly in setting back the continent from achieving the millennium development goals.

A number of questions arise from Murthy and Lakshminarayana's paper, and in the African context demand answers. The first relates to the long-term outcome of those traumatized by the various wars. Whereas there is some suggestion from Mozambique (10) that PTSD rates go down over time, other long-term studies would suggest otherwise (11,12). Indeed, eight years after the genocide in Rwanda, a quarter of the studied population showed diagnosable PTSD (7).

This, projected to the actual numbers of Africans traumatized in Sudan, Sierra Leone, Democratic Republic of Congo, Ivory Coast, Somalia and other parts of Africa, translates to millions of people in need of help.

Community interventions such as those tried in Mozambique (10) hold some promise, as do initiatives such as the South Africa Truth and Reconciliation Commission (13).

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Erratum – The address of Qi Cheng, the second author of the paper "Global suicide rates among young people aged 15-19", by D. Wasserman et al, which appeared in World Psychiatry, 4: 114-120, 2005, has been submitted and published incorrectly. The correct address is: Center of Clinical Epidemiology, Ruijin Hospital, Shangai Second Medical University, Shangai, China.

RESEARCH REPORT

First episode psychosis and ethnicity: initial findings from the AESOP study

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In this paper we provide an overview of the design and the initial findings of the AESOP (Aetiology and Ethnicity in Schizophrenia and Other Psychoses) study. The AESOP study is a major multi-centre incidence and case-control study conducted in the UK. Its primary aim is to investigate the high rates of psychosis in African-Caribbean populations from the UK, and from this to shed light on the aetiology of psychosis in general. As the study has progressed, the wealth of data collected has allowed further questions to be addressed: for example, about determinants of duration of untreated psychosis. Initial findings relating to incidence rates and between-case comparisons are presented. Future planned analyses are outlined and details of a follow-up of the AESOP cohort and ongoing international collaborations are provided.

Key words: Psychosis, ethnicity, aetiology, incidence

One of the most consistent findings in the epidemiology of schizophrenia is the high incidence of the disorder among migrant and ethnic minority groups (1). The most striking and perhaps well-known example is that of the African-Caribbean population in the UK. Since the 1960s, there have been close to twenty studies comparing rates of schizophrenia and other psychoses in this population with those among Whites (variously defined) in the UK. All have reported incidence rates to be higher for African-Caribbeans, with a range from 2 to 18 times (see 2). These findings are mirrored in studies of migrant and ethnic minority groups in other countries, most notably the reported high rates of psychosis among Surinamese migrants and descendents in the Netherlands (3). In the UK, research has consistently shown that African-Caribbeans are not only at greater risk of developing psychosis, but are also more likely to access mental health care via adversarial routes, often involving the police and compulsory admission, and more likely to be treated in secure and forensic settings (4,5).

While research to date has clearly demonstrated a greater need for mental health care among some migrant and ethnic minority groups in the UK, it has been less successful in explaining the excess rates of psychosis and of compulsory admissions, and, by extension, in informing policy and service responses.

The AESOP (Aetiology and Ethnicity in Schizophrenia and Other Psychoses) study was established to address these gaps in existing knowledge. Specifically, the initial primary aims were: a) to conduct a large population based, first contact case-control study of psychosis in which to test hypotheses concerning social and biological factors which might explain the increased incidence of schizophrenia in the African-Caribbean population in the UK; b) by determining the causes of the high incidence in this population, to throw light on the aetiology of schizophrenia in general.

As the study has progressed, the wealth of data collected has allowed a much broader range of questions to be addressed in addition to these initial aims. Hypotheses concerning pathways to care and duration of untreated psychosis (DUP) among different ethnic groups, for example, have already been investigated, and questions not specifically related to ethnicity have been examined (e.g., whether the incidence of psychosis varies geographically, what the general correlates of DUP are). As such, the AESOP study has become a much broader and far ranging study than was initially intended, and we have now begun a follow-up of the cohort that formed the basis of the baseline study.

This paper has three aims: a) to provide an introduction to, and an overview of, the design and methods of the AESOP study; b) to summarise data collected to date, focusing on incidence rates and between-case comparisons; and c) to outline future plans for the study, including planned analyses, a follow-up and international collaborations.

METHODS

The AESOP study is a multi-centre population based incidence and case-control study of first episode psychosis, conducted initially over a three-year period from September 1997 to August 2000. The study sample comprises: a) all patients with a first episode of psychosis (F10-F29 and F30-F33 in ICD-10) who presented to secondary and tertiary services within tightly defined catchment areas in south-east London, Nottingham and Bristol over defined time periods; b) where possible, a close relative of each patient; and c) a random sample of healthy community controls.

The inclusion criteria for cases were: a) age between 16 and 65 years; b) resident within tightly defined catchment areas in Nottingham, Bristol or south-east London; c) presence of a first episode of psychosis (F10-F29 and F30-F33 in ICD-10) within the time frame of the study; and d)

Table 1 Data collection instruments used in the AESOP study

Clinical	Psychosocial	Cognitive, biological
Schedules for Clinical Assessment in Neuropsychiatry [a,d]	MRC Sociodemographic Schedule [a,b,c,d]	Neuropsychological test battery [a,c]
	Culture and Identity Schedule 1 [a,c]	Neurological soft signs [a,c]
Personal and Psychiatric History Schedule [a,b,d]	Culture and Identity Schedule 2 [a,c]	Minor physical anomalies [a,c]
	Achievements and Expectations Schedule [a,c]	Family Interview for Genetics [a,b,c]
	Employment Schedule [a,c]	
	Significant Others Schedule [a,c]	Magnetic resonance imaging [a,c]
	Insight Schedule [a]	DNA [a,c]
	Childhood Experiences of Care and Abuse Questionnaire [a,c]	
	Life Events and Difficulties Schedule [a,c]	
	Mental Disorder Beliefs Schedule [a,b,c]	
	Locus of Control [a,c]	
	Self-Esteem [a,c]	
	Self-Concept [a,c]	

Used to collect data from: [a] cases; [b] relatives; [c] controls; [d] case records. Full details available from authors on request

no previous contact with health services for psychosis. Exclusion criteria were: a) evidence of psychotic symptoms precipitated by an organic cause; b) transient psychotic symptoms resulting from acute intoxication as defined by ICD-10; and c) IQ less than 50.

Case finding procedures were based on those used by the World Health Organization (WHO) in its multi-country studies of the incidence and outcome of schizophrenia (6). A team of researchers was involved in regularly checking all points of potential patient contact with secondary and tertiary health services in the catchment areas. All potential cases were screened for inclusion using the Screening Schedule for Psychosis (6), which was completed by interviewing the patient and/or using case notes and information provided by psychiatric staff. Each patient meeting inclusion criteria for the study was approached and informed consent sought. Case recruitment took place initially over two years in Nottingham and south-east London and nine months in Bristol. During the third year of the study, recruitment of African-Caribbean cases was extended in Nottingham and south-east London to increase the number of these patients in the case-control arm of the study. At the end of the period of case recruitment, a leakage study was conducted to identify further potential cases initially missed. For each patient included in the study, we also sought consent to interview a close relative who had been in recent contact with the patient.

A random population based sample of control subjects was selected using the same sampling frame as that used by the Office of Population and Census Statistics (OPCS) Psychiatric Morbidity Survey, namely the postal address file (PAF) (7). The PAF was used to generate a random sample of ten target addresses for each case from which controls were recruited. Each address was contacted three times (morning, afternoon, evening) to find an eligible control subject (age between 16 and 65 years) who was willing to participate. This method broadly matches cases and controls by area of residence. Cases and controls were otherwise unmatched, the aim being to select a sample of controls that was representative of the population from which the cases were drawn. To ensure a sufficient number of African-Caribbean controls were recruited, we over-sampled this group.

The full range of data collection instruments used is detailed in Table 1. Subjects who consented to take part completed on average 15 hours of interviews and assessments, yielding a considerable range of data.

Clinical data were collected using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (8). The SCAN incorporates the Present State Examination Version 10, which was used to elicit symptom-related data at the time of presentation. Where an interview with the patient was not possible, case notes were used to complete the Item Group Checklist (IGC) part of the SCAN. ICD-10 diagnoses were determined using the SCAN data on the basis of consensus meetings involving one of the principal investigators and other members of the research team. There was an assessment for possible bias between the principal investigators. Each independently formulated a diagnosis for 20 patients based on the same summary SCAN information. There was 80% agreement on diagnostic category (kappa values ranged from 0.63 to 0.75, p<0.001).

In assigning patients to ethnic groups, a number of data sources were used. The primary source was self-ascribed ethnicity, collected using the Medical Research Council Sociodemographic Schedule. Where this was not available, other sources were used, including other informants and case notes. Where there was ambiguity, a consensus rating was made by members of the research team; this always included those with long-standing expertise in the study of ethnicity and mental health.

RESULTS

The AESOP sample

During the study period, we identified 592 cases (330 in south-east London; 205 in Nottingham; 57 over 9 months

Table 2 Basic characteristics of the AESOP sample

	London		Nottingham		Bristol	
	Cases	Controls	Cases	Controls	Cases	Controls
Age (mean ± SD)	31.0 ± 10.5	36.1 ± 11.3	30.3 ± 11.2	38.4 ± 13.4	30.7 ± 10.8	31.5 ± 9.4
Male, N (%)	186 (56.7)	67 (36.6)	122 (59.5)	95 (45.7)	39 (68.4)	9 (42.9)
White British, N (%)	78 (23.6)	76 (41.5)	151 (73.7)	164 (78.9)	37 (64.9)	19 (90.5)
African-Caribbean, N (%)	126 (38.2)	51 (27.9)	27 (13.2)	23 (11.1)	10 (17.5)	1 (4.8)
Black African, N (%)	66 (20.0)	21 (11.5)	3 (1.5)	1 (0.5)	5 (8.8)	0 (0.0)

Table 3 Distribution of diagnoses in the AESOP patient sample

	London N (%)	Nottingham N (%)	Bristol N (%)
Non-affective psychoses	248 (75.2)	140 (68.3)	40 (70.2)
Manic psychosis	45 (13.6)	26 (12.7)	6 (10.5)
Depressive psychosis	37 (11.2)	39 (19.0)	11 (19.3)

in Bristol), and 412 controls (183 in south-east London; 208 in Nottingham; 21 in Bristol), a total of 1004 subjects. Of the cases identified, 390 (66%) consented to be interviewed. Of the remaining 202 (34%), 66 (11%) were identified as part of the leakage study and not approached to be interviewed, 58 (10%) could not be contacted or did not speak English, and 78 (13%) refused to be interviewed. Table 2 summarises the basic demographic characteristics of the study sample by case-control status and study centre, and Table 3 breaks the sample of cases down by diagnosis.

Incidence rates

Analyses of the incidence of psychosis using AESOP data have so far focused on whether there are notable variations in the incidence of psychosis by geographical area and/or ethnic group (9-11).

Using denominator data from the 2001 census, we found strong evidence that the incidence of psychosis does vary between the geographical areas covered by the study. The incidence rates for all psychoses were significantly lower in both Nottingham and Bristol (25 per 100,000 person years and 22 per 100,000 person years, respectively) compared with south-east London (55 per 100,000 person years) [incidence rate ratio, IRR: 0.5 (0.4-0.6) for Nottingham; 0.4 (0.3-0.6) for Bristol]. When the data were stratified by diagnostic group, this pattern remained across all diagnoses (schizophrenia, affective psychoses, other psychoses). Furthermore, standardising for age and sex and adjusting for ethnicity did not markedly alter these findings.

We found the incidence of all psychoses to be significantly higher in African-Caribbean and Black African populations across all three centres compared with the baseline White British population [African-Caribbeans: IRR 6.7 (5.4-8.3); Black Africans: IRR 4.1 (3.2-5.3)]. These differences were most marked for narrowly defined schizophrenia (F20) and manic psychosis (F30-31). For example, after adjusting for age, the incidence of schizophrenia across the three study centres was nine times higher in the African-Caribbean population [IRR 9.1 (6.6-12.6)] and six times higher in the Black African population [IRR 5.8 (3.9-8.4)]. The incidence rates for schizophrenia in the African-Caribbean and Black African populations (71 per 100,000 person years, and 40 per 100,000 person years, respectively) are among the highest ever reported. A strikingly similar pattern was evident for manic psychosis (F30-31). After adjusting for age, the incidence of manic psychosis was eight times higher for African-Caribbeans [IRR 8.0 (4.3-14.8)] and six times higher for Black Africans [IRR 6.2 (3.1-12.1)] compared with the White British baseline group. The rates of depressive psychosis were also raised, but more modestly [African-Caribbeans: IRR 3.1 (1.5-3.6); Black Africans: IRR 2.1 (0.9-5.0)]. Intriguingly, the incidence rates for all psychoses were also raised for all other ethnic groups (other White, Asian, mixed, other) compared with the White British populations, albeit much more modestly (IRRs for all psychoses ranged from 1.5 to 2.7).

Pathways to care and DUP

Analyses of differences between cases included in the study have so far focused on two key issues: a) whether there are ethnic variations in pathways to mental health care at first presentation; and b) what are the correlates of DUP (12-15).

When pathways to first contact with services were compared between cases from different ethnic groups, three notable differences emerged. First, both African-Caribbean and Black African patients were significantly more likely to be compulsorily admitted to hospital. Over 50% of both African-Caribbeans and Black Africans were admitted to hospital compulsorily, compared with only 24% of White British patients. African-Caribbean men were the most likely to be compulsorily admitted (61%). Second, both African-Caribbean and Black African patients were significantly more likely to access services via the police or another criminal justice agency. Over 30% of both African-Caribbeans and Black Africans were referred to mental health services via this route compared with only 12% of White British patients. Third, both African-Caribbean and Black African patients were significantly less likely to access services via a general practitioner. Less than 30% of both African-Caribbeans and Black Africans were referred to mental health services by a general practitioner compared with over 40% of White British patients. When a range of potential explanatory variables were adjusted for (e.g., indicators of social isolation, aspects of clinical presentation, other features of the pathway to care), these differences remained strong.

Surprisingly, we found that differences in pathways to care between ethnic groups could not be explained by longer delays in accessing care among African-Caribbeans and Black Africans. Indeed, we found no evidence that the DUP was longer for these patients than for White British patients.

Using data on DUP, we were able to address the important issues of which factors correlated with DUP in a multi-centre epidemiological sample. Overall, the median DUP in the AESOP sample was 9 weeks [inter-quartile range (IQR) 2-40; mean ± SD 58 ± 148 weeks]. The distribution of DUP was heavily skewed, with the majority of patients accessing treatment within 10 weeks of onset and the minority presenting much later, often in excess of 2 years. We found that four variables were strongly associated with a long DUP: an insidious mode of onset (median DUP 32 weeks; IQR 11-99); a diagnosis of schizophrenia (median DUP 13 weeks; IQR 3-53); being unemployed (median DUP 13 weeks; IQR 4-52); and absence of family involvement in seeking help (median DUP 12 weeks; IQR 3-54). Each of these variables remained significantly associated with a longer DUP after adjusting for potential confounders, including age at onset, sex, and study setting. No other social variables (living alone, being single, poor education) were associated with a longer DUP.

DISCUSSION

The AESOP study is one of the largest studies of first episode psychosis. In recruiting a large cohort of cases and controls and collecting data relating to both a wide range of risk factors for psychosis and a range of service use related variables, we are able to test a host of important hypotheses.

Methodological issues

The validity of findings from previous studies of the incidence of schizophrenia and other psychoses among different ethnic groups in the UK has been challenged on methodological grounds. Serious questions have been raised about: a) the accuracy of denominator data for ethnic minority groups; b) completeness of case ascertainment; and c) diagnostic validity across different ethnic groups. In relation to each of these, the AESOP study marks an improvement on most previous research. Firstly, it is the first to use data from the 2001 census, which probably has the most accurate estimates of ethnic minority populations to date (although it is not flawless). We also repeated the analyses of incidence rates for different ethnic groups using 1991 census data, with no notable differences in the findings. Given the level of population underestimation required to explain, for example, an up to 10-fold increased incidence of schizophrenia among African-Caribbeans, it is highly unlikely that inaccurate denominator data could explain our findings. Secondly, our case ascertainment methods were comprehensive, drawing on the WHO Ten Country Study and the experience of researchers in the study centres, to ensure as complete coverage as possible of all possible points of service contact for patients with a first episode of psychosis. Further, leakage studies conducted at the end of the period of case recruitment increase our confidence that the overwhelming majority of new cases of clinically significant psychosis were identified. Of course, it is likely that a small minority of cases were missed but, for this to explain our findings, the missed cases would have to have been disproportionately White British and the numbers significant. Thirdly, diagnoses were made by consensus, blind to ethnicity, on the basis of all available information, including data from SCAN interviews. This approach again broadly replicates the methods used in the WHO studies and studies of the incidence of psychosis in Caribbean countries, which have revealed incidence rates similar to those for the White British in the UK. This reduces possible diagnostic biases, and again, for the findings to be fully explained by misdiagnosis of ethnic minority cases, the level of error would have to have been substantial.

Incidence rates

The absence of a statistically significant difference in the incidence of narrow schizophrenia between the countries included in the WHO Ten Country Study has led many to contend that the incidence of schizophrenia is uniform across the globe, and that therefore schizophrenia must be a predominantly genetic disorder (6). Recent reviews by McGrath et al (16) and Cantor-Graae and Selten (1), however, in providing evidence of substantial variations across place and persons, challenge this view. Our findings that the incidence of all psychoses vary by geographical area and ethnic group contribute to the growing evidence that the incidence of schizophrenia and other psychoses is not uniform. In particular, the finding that the incidence of psychosis is higher in south-east London, a much more urbanised and heavily populated area than either Nottingham or Bristol, provides some support for the suggestion that urbanicity is a risk factor or indicator for psychosis (17).

With regard to ethnicity, our findings of marked variations in incidence rates support previous studies showing high rates of schizophrenia in African-Caribbean populations in the UK, and extend these by showing that: a) rates of all psychoses are high; and b) rates are similarly elevated in the Black African population in the UK. Given that the AESOP study overcomes many of the methodological limitations that have characterised previous studies in this area, the weight of evidence is such that there can now be little doubt that there is a genuine and marked excess of psychotic illness in African-Caribbean and Black African populations in the UK. Further, the AESOP study is the first incidence study with sufficient numbers of cases from other ethnic groups (including other Whites) to allow reasonably accurate estimates of incidence in these groups. What our findings suggest is that the incidence of psychoses in these groups is elevated compared with the White British population, but more modestly than for African-Caribbeans and Black Africans. This mirrors the conclusion drawn by Cantor-Graae and Selten (1) that there is a general increased risk for migrant and ethnic minority groups, but that this risk is highest "for those migrants from areas where the majority population is black". Understanding this difference may be key to explaining the high rates among African-Caribbeans and Black Africans, and may provide important clues more generally concerning the aetiology of psychosis. It is this that the case-control component of the AESOP study is attempting to achieve.

Pathways to care and DUP

Data relating to pathways to care and DUP from the AESOP study challenge some previous assumptions. For example, studies by Burnett et al (18) and Cole et al (19), both small first onset studies, showed no differences in the proportions of compulsory admissions among different ethnic groups at first contact, leading to the suggestion that differences emerged over time, in the course of repeated contacts with services (20). This view has important implications as it suggests that a major reason for the greater use of compulsion among African-Caribbeans is that they have more negative experiences of services, leading them to disengage and resist intervention in the event of relapse, consequently increasing the risk of subsequent compulsory intervention. The data from the AESOP study strongly suggest that there are ethnic differences at first contact, and consequently that processes must be operating within these communities to increase the risk of an adverse pathway to care prior to contact with services. Understanding what these processes are is a key challenge for future research. What seems clear, however, is that African-Caribbeans do not, as is commonly assumed, experience longer treatment delays leading them to present in crisis when the need for compulsion is greater.

Our findings more generally regarding DUP are equally important. What they suggest is that the time from onset of psychosis to contact with services is influenced both by aspects of the early illness course (mode of onset, initial diagnosis) and the social context (unemployment, family involvement, service context). This has potentially important implications for developing early intervention services. While on the one hand our findings suggests that DUP is, to a degree at least, shaped by malleable social factors and that strategies may be possible to reduce delays, on the other hand they suggest that DUP is strongly associated with other aspects of early illness course that predict poor outcomes (particularly an insidious mode of onset). This further emphasises the need for future studies of the relationship between DUP and outcomes to more fully adjust for these potential confounders. In short, our findings emphasise that it is still possible that the association between DUP and outcomes is confounded, and, while ever this is the case, greater caution is needed before basing wholesale service reforms on the reported association between DUP and outcomes.

Realising the AESOP study's potential

The primary focus of the next stage of analyses will be on case-control comparisons, the primary purpose being to investigate hypotheses relating to the excess of psychosis among African-Caribbeans and Black Africans. For example, early analyses focusing on childhood separation from parents and adult social exclusion have produced some indications that these factors may be important in explaining, at least partly, the excess of psychosis among African-Caribbeans (21), confirming the findings of Mallett et al (22) from a smaller study. Further hypotheses regarding the potential effects of ambivalent cultural identity, unemployment and life events will be investigated using data collected using two Culture and Identity Schedules (20), the Employment Schedule (23) and the Life Events and Difficulties Schedule (24). Data collected relating to brain structure, neuropsychology and family history will allow further hypotheses regarding biological and cognitive risk factors to be investigated. The first stage of these analyses is, therefore, very much about identifying or replicating specific risk factors. The major strength of the AESOP study, however, is that it will allow models to be built that investigate the relative impact of specific factors and interactions between them. It is envisaged that these kinds of analyses will be built on the foundations of the more traditional risk factor analyses outlined above, and it is this that will reveal the full potential of this unique data set.

Intriguing findings that have emerged from initial analyses of AESOP's biological data illustrate this. We have already found, for example, that there is an excess of focal neurological signs and of motor coordination problems in patients (compared with controls), perhaps reflecting vulnerability to psychosis. This is supported by our magnetic resonance imaging findings to date, which show that an excess of these signs in patients (but not controls) is associated with a smaller volume of basal ganglia and thalamus (25,26). These findings are unaccounted for by the effect of treatment with antipsychotic medication (27). Tentatively, this suggests that motor dysfunction and focal neurological signs in psychosis may be the functional correlates of abnormalities of the integrative functions performed by structures involved in the pathogenesis of schizophrenia, such as the basal ganglia and the thalamus. Further, we have evaluated the volume of the pituitary gland, reporting a marked enlargement of this gland (18%) in patients compared with healthy controls. This enlargement provides indirect evidence of activation of the hypothalamic-pituitary axis (28), and opens up further interesting potential avenues for combining our social and biological risk factor data to look at the role of stress.

Future directions: follow-up and international collaborations

Analysis of the baseline AESOP data is very much ongoing. Alongside this there are two further developments that are enhancing this programme of research: a follow-up study and international collaborations.

When the AESOP study was established, one aim was to create a cohort of individuals with a first episode of psychosis who could be followed up over time. During the past year we have successfully conducted a pilot 6-8 year follow-up of 100 subjects (50 cases and 50 controls) initially recruited to the AESOP study, collecting data relating to course and outcome (both clinical and social), neuropsychological function, brain structure, and forensic history, and, funding permitting, we will now extend this to the full sample, allowing important questions to be addressed concerning determinants of outcome following a first episode of psychosis.

As the AESOP study has progressed, a number of international collaborations have been established, resulting in studies being set up in four other countries, which are based to a greater or lesser degree on the AESOP protocol: Trinidad, Brazil (Sao Paulo), Northern Ireland (Belfast) and Italy (Verona). Parallel studies in different social and cultural contexts offer considerable opportunities for comparisons, and already some initial work is yielding interesting findings. In Trinidad, for example, over 400 first episode cases of psychosis have been recruited and early analyses indicate a higher incidence among African-Trinidadians compared with Indo-Trinidadians (29). Further, comparisons of the role of social risk factors and differences in pathways to care in Trinidad and the UK promise to enhance our understanding both of the aetiology of psychosis and of patient and family responses to psychosis in different cultural settings. We are, moreover, keen to extend our international collaborations to create a network of first onset studies across the world, and new possibilities are already being explored. In this way, we can build on the AESOP study, and the findings of individual studies can be collated and compared, providing unique new insights into, and answering important questions about, psychosis.

APPENDIX

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RESEARCH REPORT

Genetic and environmental origins of health anxiety: a twin study

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Excessive health anxiety – which is anxiety about one's health that is disproportionate to the person's medical status – is a common and often debilitating problem. Little is known about its etiology. The present study investigated the role of genetic and environmental factors using a classic twin study method. Results indicated that, after controlling for medical morbidity, environmental influences accounted for most of individual differences in health anxiety. These findings underscore the importance of psychosocial interventions, which have been shown to be among the most effective interventions for excessive health anxiety.

Key words: Health anxiety, genetic factors, environmental factors, psychosocial interventions

Excessive health anxiety is common, often debilitating, and leads to frequent consultations from general medical professionals and mental health specialists. Health anxiety ranges from mild to severe, and is considered maladaptive if it is out of proportion with the person's objective medical status. There are several facets of health anxiety, including health-related fears (i.e., fear that one might succumb to disease, pain, or death), disease conviction (belief that one has a serious disease), excessive health-related behaviors (e.g., needless reassurance-seeking from physicians), and functional impairment (e.g., impairment in occupational functioning because of preoccupation with bodily sensations). When these facets are sufficiently severe and prolonged, the person is likely to meet diagnostic criteria for hypochondriasis (1-4).

Hypochondriasis often arises when the person is under stress, seriously ill, or recovering from a serious illness, or has suffered the loss of a family member (5). Health-anxious people may have a coexisting general medical condition that fuels their anxiety. Psychosocial interventions have been shown to be among the most effective interventions for excessive health anxiety, which suggests that environmental factors play an important role in this disorder. This was supported by Torgersen (6), who found that the concordance rate for lifetime history of somatoform disorders did not significantly differ between monozygotic (MZ) and dizygotic (DZ) twin pairs, despite the two-fold greater genetic similarity of MZ to DZ twins.

A major problem in interpreting Torgersen's results is the very small sample size (N = 35 twin pairs), along with the low population base-rate of hypochondriasis – lifetime prevalence = 1-5% (1) – which would make estimates of concordance in that study highly unreliable.

Larger studies of MZ and DZ twins have examined the heritability of hypochondriasis using the Minnesota Multiphasic Personality Inventory (MMPI) Hypochondriasis (Hs) scale. Results suggested that hypochondriasis is moderately heritable, with genetic factors accounting for up to 35% of the variance in Hs scores (7,8). A problem with these studies was that the MMPI is a poor measure of hypochondriasis, because it assesses awareness of bodily sensations rather than hypochondriasis per se. At best, these studies indicate that one correlate of health anxiety – the tendency to experience recurrent bodily sensations – is moderately heritable.

The goal of the present study was to estimate the relative effect of genetic and environmental factors on the variability of health anxiety measures using a sufficiently large sample and a suitably valid assessment instrument. Unlike any previously published research, this study estimated the heritability of *excessive* health anxiety; that is, the heritability of health anxiety once the effects of medical morbidity were statistically controlled. Prior studies, including studies of patients diagnosed with hypochondriasis, have failed to control for the fact that even many hypochondriacal patients have genuine medical problems that may fuel their health anxiety (4). Many general medical conditions are heritable. Accordingly, in order to investigate the heritability of health anxiety, it is necessary to control for general medical morbidity. Given that health anxiety ranges on a continuum of severity, from mild to full-blown hypochondriasis, we used a general population sample rather than a sample of hypochondriasis patients. A general population sample does not suffer from problems of range restricting in health anxiety scores which would occur if a hypochondriasis sample was used. Range restriction can result in the attenuation of correlations among variables, such as genetic correlations.

METHODS

Participants

The sample consisted of 88 MZ and 65 DZ twin pairs. They were recruited through media announcements for participation in twin research made in major metropolitan centers across Canada, as part of the University of British Columbia Twin Project (9). Most (80%) were female and the mean age was 39 years (SD = 14). Zygosity was determined using an accurate questionnaire (10), along with examination of recent color photographs. Each twin pair was reared together, and all were fluent in written and spoken English. All participants provided written informed consent, and received an honorarium for completing the study.

Materials and procedure

Twin pairs independently completed a battery of questionnaires in a non-distracting setting at home. This included the Illness Attitude Scales (IAS) (11), which is among the most widely used measures of health anxiety, and has good reliability and validity (4). Factor analytic research indicates that the original nine IAS subscales can be reduced to four subscales, which were used in the present study: intensity of fear of illness, disease, pain, and death; degree of interference in functioning caused by bodily sensations; frequency of treatment-seeking behavior; and strength of disease conviction (12). These dimensions correspond to the major facets of full-blown and subclinical hypochondriasis (1,4). Thus, the IAS assesses a range of health anxiety, from mild to severe.

The IAS also contains sections in which participants are asked to write down any diagnoses and treatments they have obtained from their physicians. In the present study this information was used to gauge each patient's medical morbidity. This was done in an attempt to assess excessive health anxiety separate from any realistic anxiety associated with medically verified diseases. Logistic constraints on data collection did not enable us to obtain data from medical charts or perform physical examinations on the participants. The medical conditions described by the participants were grouped into thirteen categories: gastrointestinal disorders (e.g., ulcerative colitis), cardiovascular diseases (e.g., atrial fibrillation), thyroid conditions (hypo- or hyper-thyroidism), respiratory disorders (e.g., emphysema), gynecological problems (e.g., endometriosis), diabetes, kidney disease, liver disease, neurological disorders (e.g., multiple sclerosis), hematological diseases (e.g., pernicious anemia), chronic pain conditions (e.g., arthritis), chemical sensitivity, and chronic fatigue syndrome. Each participant was given a score of 0 or 1 for each category (absent or present) and the scores were summed across all categories. This likely represents a conservative measure of medical morbidity; it is likely to overestimate to the true severity of medical morbidity because health-anxious people often have the unfounded belief that they have been diagnosed with a general medical condition.

As a check on the validity of our medical morbidity scale, we tested several predictions: scores on this scale should be correlated with age, uncorrelated with gender, correlated with the dimensions of health anxiety (i.e., medical diseases are a source of anxiety), and should be at least moderately heritable (because many diseases have a heritable component). These predictions were largely confirmed. The medical morbidity score was positively correlated with age ($r = .23$, $p<0.01$), uncorrelated with gender (coded such that women = 1, men = 0; $r = -.04$, $p>0.1$), and significantly correlated with the IAS interference, treatment, and conviction dimensions (r ranged from .16 to .20, $p<0.01$) but not with the fear dimension ($r = .07$, $p>0.1$). Scores on the medical morbidity scale were also moderately heritable (heritability = .37). Thus, the scale had acceptable performance on the validity tests.

Statistical procedures

Scores on the medical morbidity scale were partialled out of all scores on the IAS measures of health anxiety. Age and gender were uncorrelated with health anxiety ($r < .10$, $p>0.08$). MZ and DZ within-pair correlations were decomposed via standard biometric structural equation modeling into variance components attributable to additive genetic influences (A), shared environmental influences (C), and nonshared environmental influences (E). This was done by the method of least squares with asymptotic weights using the Mx program (13,14). Additive genetic effects are those that cumulatively influence a given trait (i.e., they are not dominant or epistatic effects). Shared environmental effects are experiences that cause children from the same family to be similar to one another (e.g., a similar standard of living stemming from the parent's income level). Nonshared environmental effects are any experiences that cause children from the same family to be different from one another (e.g., parental favoritism, or an accident to one sibling but not the other). To estimate the degree to which the various dimensions of health anxiety share a common genetic or environmental basis, genetic (r_G) and environmental correlations (r_E) were also computed. They are interpreted in the same way as any other measure of association, such as Pearson's r. To illustrate, the larger the genetic correlation for a pair of variables, the greater the similarity or overlap in the genetic factors that contribute to those variables. If a pair of variables had a large genetic correlation, then that would suggest that they arose from common genetic factors. A low genetic correlation would indicate that they arose from different sets of genes. Environmental correlations are interpreted in the same way.

RESULTS

Table 1 presents the estimates of genetic and environmental influences on individual differences in health anxiety. All scales were modestly heritable, with genetic influences accounting for less than 40% of variability. In contrast, environmental factors accounted for the majority of the variability in the scales (60% to 90%).

Table 2 shows the environmental and genetic correlations among the dimensions of health anxiety. The genetic correlations between scales are generally quite large, suggesting

Table 1 Within-pair correlations, model fit statistics, and parameter estimates for scores on the dimensions of health anxiety (after partialling out the effects of medical morbidity)

			Statistics (χ^2) for fit of model of genetic and environmental effects				**Proportion of variance attributable to each effect**		
	r_{MZ}	r_{DZ}	ACE	AE	CE	E	h^2	c^2	e^2
Fear of illness, disease, pain, and death	.59	-.03	5.54	**5.54**	10.01	13.59	.37	.00	.63
Interference in functioning caused by bodily sensations	.36	.11	0.26	**0.26**	2.24	12.39	.34	.00	.66
Frequency of treatment-seeking	.19	.02	0.44	**0.44**	0.99	1.70	.13	.00	.87
Disease conviction	.37	-.21	9.36	**9.36**	10.09	10.09	.10	.00	.90

Models fitted using asymptotic weighted least squares. Best-fitting model is in boldface. MZ = monozygotic twins; DZ = dizygotic twins; A = additive genetic effects, C = common (shared) environmental effects, E = non-shared environmental effects, h^2, c^2, and e^2 = proportion of variance due to, respectively, additive genetic factors, common environmental effects, and non-shared environmental effects

Table 2 Genetic correlations (in boldface, above dashes) and nonshared environmental correlations (below dashes) among dimensions of health anxiety (after partialling out medical morbidity)

	Fear of illness, disease, pain, and death	**Interference in functioning caused by bodily sensations**	**Frequency of treatment-seeking**	**Disease conviction**
Fear of illness, disease, pain, and death	-	**.53***	**.44**	**.91***
Interference in functioning caused by bodily sensations	.18*	-	**.69***	**.75**
Frequency of treatment-seeking	.11	.31*	-	**.99**
Disease conviction	.29*	.25*	.05	-

Based on AE models (see Table 1) fitted with asymptotically weighted least square
*p<0.05

that the dimensions of health anxiety are influenced by a common set of genetic factors. Despite their magnitude, not all correlations were statistically significant (this is because the significance of the correlation is a function of the standard errors of the measures). The environmental correlations are much more modest in size, suggesting that most of the environmental influences are dimension specific.

DISCUSSION

The present study is the first to use psychometrically sound measures and a suitably large sample size to investigate the role of genetic and environmental factors in excessive health anxiety (i.e., health anxiety in excess of the person's medical morbidity). Consistent with some of the better earlier research (i.e., the studies using a sufficient sample size, even if those studies used inadequate measures) (7,8), we found evidence that some of the dimensions of health anxiety are moderately heritable. Previous research by DiLalla et al (7) and Gottesman (8) suggested that genetic factors accounted for 35% of variance in health anxiety scores (as assessed by the MMPI Hs scale), whereas the present study indicates that, for the two most heritable dimensions (fears and interference), genetic factors account for 34-37% of variance. The other two dimensions (treatment-seeking and disease conviction) accounted for 10-13% of variance. Our findings are consistent with previous conjectures that health anxiety is largely a learned phenomenon (15,16). The environmental correlations suggest that each dimension of health anxiety arises from a dimension-specific form of environmental (e.g., learning) factor. The nature of these factors remains to be elucidated.

Our findings support the use of environmental interventions, such as psychosocial (cognitive-behavioral) treatments for health anxiety. These are among the most effective interventions (4). Although they appear to be at least as effective as empirically supported pharmacotherapies for health anxiety (e.g., selective serotonin reuptake inhibitors, SSRIs), evidence suggests that the psychosocial interventions have good long-term efficacy, whereas the long-term effects of pharmacotherapies remain to be investigated (4).

The present findings, which suggest that genetic factors play some role in excessive health anxiety, also raise the question of whether pharmacological treatment can be improved by tailoring medications to the person's genotype. Treatment studies for major depression indicate that the efficacy of SSRIs is greater for patients who possess two long alleles of the serotonin transporter gene, compared to patients possessing one or two short alleles (17). The same might be true for excessive health anxiety. More generally, given that excessive health anxiety arises from a combination of genetic and environmental factors, it may be that the optimum treatment involves some combination of pharmacological and psychosocial interventions.

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Undergraduate student mental health at Makerere University, Uganda

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There is little information on the current mental health of University students in Uganda. The present study was carried out to determine the prevalence of depressed mood and suicidal ideation among students at Makerere University. Two student samples participated. Sample I comprised 253 fresh students admitted to all faculties at the University in the academic year 2000/2001, selected by a simple random sampling procedure. Sample II comprised 101 students admitted to the Faculty of Medicine during the academic year 2002/2003. The prevalence of depressed mood was measured using the 13-item Beck Depression Inventory (BDI). The prevalence of depressed mood (BDI score 10 or more) was significantly higher in sample I (16.2%) than sample II (4.0%). Sample I members were significantly more likely than those of sample II to report lifetime and past week suicide ideation. Thus, there is a high prevalence of mental health problems among the general population of new students entering Makerere University and this is significantly higher than for new students in the Faculty of Medicine.

Key words: Students, mental health problems, depressed mood, suicidal ideation

In Uganda, many students who join University and other institutions of higher learning have lived through a variety of difficulties, including high levels of poverty, loss of traditional social support and HIV/AIDS epidemic. Under these circumstances, it would be expected that, with the added pressure of studies, University students would exhibit high levels of psychological distress. However, the prevalence of mental health problems among University students in Uganda is unknown. The present study was carried out to determine the prevalence of probable depressed mood and suicidal ideation among two populations of fresh students at Makerere University, Kampala.

METHODS

Two samples were taken from undergraduate students at Makerere University. The first (sample I) included 253 students from all faculties joining various courses during the academic year 2000/2001. The second (sample II) included 101 students taken from those joining the Faculty of Medicine during the academic year 2002/2003. At the time of surveys, free peer counseling services were readily available to the group admitted during the academic year 2002/2003, but not to the rest of the student body, even though counseling and guidance services were available at the University Hospital.

The thirteen-item Beck Depression Inventory (BDI) (1) was used to estimate the probable prevalence of depression. The BDI was scored on a four-point scale from 0 to 3, giving a possible range of 0-39. A score of 10 or above was considered to be indicative of probable depression.

The prevalence of suicide ideation was measured with a frequency count of "yes" response to each of the following questions which are included in the Response Inventory for Stressful Life Events (RISLE) (2-4): a) Have you ever experienced suicide thoughts along with the wish to end your life by suicide? b) Did you experience suicide thoughts along with the wish to end your life by suicide last week?

Data were entered using Epi Info version 6.04 and analyzed with SPSS version 11.0. P-values, odds ratios and 95% confidence intervals were calculated to determine significance levels.

RESULTS

Sample II students were older than sample I (mean age 23.5 ± 5.0 compared to 21.3 ± 2.4 years, $t = -4.026$, df = 334, $p = 0.0001$). There was no statistical difference in marital status between sample I (7.3% married) and sample II (14.1% married) ($\chi^2 = 2.9$, df = 1, $p = 0.09$, OR = 0.48, 95%CI = 0.20-1.12). There were no significant differences between the two groups for distribution by sex (63.6% males in sample I and 69% in sample II; $\chi^2 = 0.69$, df = 1, $p = 0.40$, OR = 1.27, 95%CI = 0.76-2.17). Twenty nine students (11.5%) in sample I had paid employment in addition to their studentships, while no student in sample II had additional employment.

Thirty-seven respondents out of 228 (16.2%) from sample I and four respondents (4.0%) from sample II attained a BDI score of 10 or higher ($\chi^2 = 8.49$, df = 1, $p = 0.004$, OR = 4.67, 95%CI = 1.61-18.50).

Sample I members were more likely than those of sample II to report lifetime experience of suicide ideation (56.0% vs. 8.9%, $\chi^2 = 63.32$, df = 1, $p = 0.00001$, OR = 6.3, 95%CI = 6.15-30.42) and past week experience of suicide ideation (15.5% vs. 1.0%, $\chi^2 = 13.49$, df = 1, $p = 0.0002$, OR = 15.5, 95%CI = 2.96-41.38). There were no significant differences on any variable between males and females in either sample.

DISCUSSION

The rate of depression of 16.2% for the first year general University sample based on BDI scores of 10 or higher is close to the rate of 13.7% that Ovuga et al (5) reported using the RISLE among a comparable sample of fresh students at Makerere University six years earlier, but higher than that reported by German and Arya (6) (10.8%), who used hospital records in their study. In an investigation carried out in students in Turkey, Bostanci et al (7) reported a prevalence rate of 32.1% for depression using the 21-item BDI, with depression being associated with poor academic performance. In a study from Sao Paulo, Brazil, Nogueira-Martins et al (8) reported a depression rate of 44% and a suicidal behavior rate of 18%, with depression being responsible for 4.5% of suspensions of studies. Results from Ibadan, Nigeria indicated that 12% of pre-clinical students (9) and 21% of clinical students (10) had mental health problems due to family problems, financial hardships, difficulties in relationships and fear of examinations.

Completed suicide does occur among students at Makerere University, and the present results confirm that the risk of suicide exists, with both student samples reporting lifetime suicide ideation, and past week experience of suicide ideation, although the rates were significantly higher in the first year general University sample.

A recent study by Nalugya (11) indicated a high rate of mental disorders (21%), mainly depression and anxiety disorders, among secondary school students in Mukono district, Central Uganda, suggesting that students joining Makerere University might have carried their mental health conditions from earlier years. The results suggest the need for the provision of mental health promotional services at the University, including mental health educational and screening services.

The Faculty of Medicine already has counseling services provided by trained student peer counselors. Though the effectiveness of the service has not been evaluated, it is possible that the low rate of depressed mood among students of the sample II of the present study is to be partly attributed to the availability of student peer counseling services at the Faculty. It is also probable that the lower rate of depressed mood in sample II was due to the tendency of medical students to deny and avoid help-seeking for the experience of emotional problems (12).

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Renaming schizophrenia: a Japanese perspective

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In order to contribute to reduce the stigma related to schizophrenia and to improve clinical practice in the management of the disorder, the Japanese Society of Psychiatry and Neurology changed in 2002 the old term for the disorder, "Seishin Bunretsu Byo" ("mind-split-disease"), into the new term of "Togo Shitcho Sho" ("integration disorder"). The renaming was triggered by the request of a patients' families group. The main reasons for the renaming were the ambiguity of the old term, the recent advances in schizophrenia research, and the deep-rooted negative image of schizophrenia, in part related to the long-term inhumane treatment of most people with the disorder in the past. The renaming was associated with the shift from the Kraepelinian disease concept to the vulnerability-stress model. A survey carried out seven months after renaming in all prefectures of Japan found that the old term had been replaced by the new one in about 78% of cases. The renaming increased the percentage of cases in which patients were informed of the diagnosis from 36.7% to 69.7% in three years. Eighty-six percent of psychiatrists in the Miyagi prefecture found the new term more suitable to inform patients of the diagnosis as well as to explain the modern concept of the disorder. The Japanese treatment guideline for "Togo Shitcho Sho" was developed in 2004 under the framework of the vulnerability-stress model.

Key words: Schizophrenia, stigma, renaming, vulnerability-stress model

Schizophrenia is one of the leading causes of disability-adjusted life years (DALYs) lost and years of life lived with disability in 15-44-years-olds in the world (1). In Japan, 260,000 patients with schizophrenia were treated every day in 1999, and 202,012 were admitted to a mental hospital in 2002. Patients with schizophrenia represented 53% of all inpatients with mental disorders in 2002, and their mean duration of hospitalization was 363.7 days in the same year.

After the 2001 World Health Day, a series of initiatives have been implemented in Japan to promote a community-based care instead of hospital-centered care. While the WPA Global Programme against Stigma and Discrimination because of Schizophrenia (2) was initiated in 1996, the Japanese Society of Psychiatry and Neurology (JSPN) had started its efforts to tackle the misunderstandings and deep-rooted prejudices about schizophrenia already in 1993. Part of these efforts has been the replacement of the old Japanese term for schizophrenia – "Seishin Bunretsu Byo" (i.e., "mind-split-disease") – by the new term "Togo Shitcho Sho" ("integration disorder"). The new term was approved by the JSPN General Assembly in August 2002. This paper reviews the impact of the renaming on psychiatric practice in Japan.

BACKGROUND OF THE RENAMING OF THE JAPANESE TERM FOR SCHIZOPHRENIA

In 1993, the National Federation of Families with Mentally Ill in Japan (NFFMIJ) requested the JSPN to replace the term "Seishin Bunretsu Byo" by a less stigmatizing one. The JSPN Committee on Concept and Terminology started to examine the request in 1995. After a series of questionnaire surveys, symposia and workshops at the annual JSPN meeting, it was decided to change the old term into a new one, provided that: a) the change did not result in any disadvantage to the patients, and b) the term conveyed the concept that schizophrenia is a disorder defined by a clinically significant syndrome, but not a disease defined by a specific etiology, symptomatology, clinical course and pathological findings. The Committee examined several alternatives, and finally selected the term "Togo Shitcho Sho" ("integration disorder"). After surveys involving the NFFMIJ, the citizens and JSPN members on the appropriateness of the new term and a public hearing, the JSPN Board accepted the new term, which was finally approved by the JSPN General Assembly in August 2002.

REASONS FOR THE RENAMING

The first reason for the renaming was the need to remove the harmful impact of the diagnosis with the old term on the patients and their families. In Japan, many psychiatrists hesitated to inform the patients of the diagnosis of schizophrenia using the old term, because of the possible negative consequences on treatment adherence and outcome. For instance, Ono et al (3) reported in 1999 that 52% of JSPN Council members informed their patients of the diagnosis of schizophrenia only occasionally on a case-by-case basis, and only 7% of them informed all their patients of the diagnosis. Thirty-seven percent of the members informed only the patients' families. On the other hand, Koishikawa (4) reported in 1997 that only 16.6% of the patients and 33.9% of their families were able to report correctly the diagnosis. This means that approximately 167,000 patients with schizophrenia in Japan spent in a psychiatric ward more than one year (on average) without knowing what their diagnosis was. These findings indicate a serious communication gap among psychiatrists, patients and their families, which makes collaborative treatment and psychoeducation more difficult.

The old term identified the patient as a person with a disorganized personality even after recovery or full remission. That is, once the diagnosis of "Seishin Bunretsu Byo" was made, the patient was usually regarded as an essentially ill person throughout his or her life. This was the main reason why the NFFMIJ required the JSPN to change the old term.

Moreover, in many Japanese textbooks of psychiatry up to the 1970s, “Seishin Bunretsu Byo” was essentially described following the concept of dementia praecox. It was characterized by a poor prognosis and a chronic process of deterioration, eventually leading to decay of personality. It required the physician to evaluate how the process of deterioration was progressing. Not surprisingly, according to a survey carried out in 1996 (5), 77.3% of JSPN Council members thought that the general image of schizophrenia in the community was that of an untreatable disease.

However, since the 1970s, Bleuler (6), Harding et al (7), Ciompi (8) and others reported in long-term outcome studies of schizophrenia that a majority of patients may recover. Ciompi proposed a complex bio-psychosocial view of schizophrenia (9) based upon the vulnerability-stress model (10). Thus, schizophrenia is currently conceptualized as a clinically significant syndrome, whose etiology and pathophysiology are not yet firmly established.

Along with the modern advances in neurosciences and the development of pharmacological and psychosocial interventions, the investigation of the biological risk factors for schizophrenia and the achievement of social integration of the patients are two main themes of schizophrenia research in Japan. These recent research advances also contributed to convince the JSPN to abandon the old name as well as the old concept of the disorder.

A further reason for the stigmatization attached to the old term is the history of inhumane treatment of patients with “Seishin Bunretsu Byo” in the first half of the 20th century. In those days, families were obliged to take custody of these patients by a special legislation (“Seishin Byo Sha Kango Ho”). Several patients were confined to a small isolated room or a hut under restraints. This law was replaced in 1950 by a Mental Hygiene Law, subsequently revised in 1965. A Mental Health Law and a Mental Health and Welfare Law were then implemented in 1987 and 1995, respectively. After this continuing effort, psychiatric treatment and care in today’s Japan has improved remarkably. Contrary to this, the stigma caused by this long history of exclusion and inhumane treatment remains deeply rooted even now.

The new term for schizophrenia (“Togo Shitcho Sho”) refers to the vulnerability-stress model, and implies that the disorder may be treated and that recovery is possible if a combination of advanced pharmacotherapy with appropriate psychosocial intervention is used. In Japan, we use this model for the investigation of biological vulnerability for schizophrenia and in clinical practice.

SPREAD OF THE NEW TERM AFTER RENAMING

After the official approval of the new term, the frequency of appearance of the old and new term in reports from mental hospitals was examined monthly in the Miyagi Prefecture and Sendai City (n = 1,944). Six months after the renaming, the new term was used in 85.5% of cases in Sendai City and 74.5% of cases in the Miyagi Prefecture. A similar survey was carried out in all prefectures of Japan seven months after renaming. The new term was used in an average of about 78% of cases in these reports (n = 17,108) (11).

Nishimura and Ono (12) reported that the percentage of cases in which patients were informed of the diagnosis increased from 36.7% in 2002 to 65.0% in 2003 and eventually to 69.7% in 2004. They also reported that 98.0% of those who usually informed the patient of the diagnosis used the new term in 2004, compared to 68.0% and 86.0%, respectively, in 2002 and 2003. However, 35.9% of them also used the old term concomitantly. Thus, the use of the new term clearly increased the frequency with which patients were informed of the diagnosis.

In our survey of 136 members of the Miyagi College of Psychiatrists carried out 13 months after the renaming (11), 86% of the respondents found the new term easier to inform patients of the diagnosis as well as to explain the concept of the disorder. Eighty-two percent of them found the new term more suitable to obtain consent to treatment from patients, useful to improve treatment compliance, effective to reduce stigma, and promising for achievement of social integration.

The College of Chairman Psychiatrists of Japan published in 2004 the Practice Guideline for the Treatment of Schizophrenia (13) using the new term and the vulnerability-stress model. This guideline recommends: a) a community-based care instead of hospital-centered care; b) a multi-axial assessment based on the DSM-IV-TR for the formulation of a treatment plan including medication and psychosocial intervention; c) a treatment plan adequately formulated for acute, remission and stable phases; d) the establishment of a therapeutic alliance including psychiatric social workers.

The above process is to be regarded as part of the WPA Global Programme against Stigma and Discrimination because of Schizophrenia. It kindled a series of anti-stigma activities in many areas of Japan (14) and contributed to new policies implemented by the government (15). It may represent a useful model for other countries worldwide.

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MENTAL HEALTH POLICY PAPER

The development of psychiatric reform in Slovenia

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The situation of mental health care in Slovenia is briefly reviewed. The reduction of beds in psychiatric hospitals has started already in the 1970s; a further decrease has occurred in the last few years. The number of admissions to these hospitals has increased recently, while hospitalizations have become shorter. On the other hand, the access to psychiatric outpatient facilities is becoming increasingly difficult. Under these circumstances, it is necessary to enhance community mental health care. Patients and families have great expectations about the new mental health legislation, which is supposed to be associated with a national mental health program.

Key words: Slovenia, psychiatric hospitals, outpatient facilities, psychiatric reform

Slovenia is a central European country with 2 million inhabitants that recently joined the European Union. The care for people with severe mental disorders in this country is traditionally associated with psychiatric institutions, without any obvious political or professional intent to redistribute health resources at the community level or integrate mental health services with general primary care.

The number of beds in psychiatric hospitals has been actually reduced already in the 1970s, but without establishing complementary services in the community: chronic patients were de-hospitalized to asylums or old people homes or returned to their families. A majority of hospital population was quickly discharged 20 years ago, mostly with very little preparation and due to economic pressure. In the central Slovenian psychiatric hospital (University Psychiatric Hospital Ljubljana, PH) there are now only about 2% long-term hospitalized patients.

During the last few years, the number of admissions to PH has been rapidly increasing, while hospitalizations have become shorter, mostly as a result of a further reduction in the number of psychiatric beds (22% from 1998 to 2004). The funding of PH is stable and is not adjusted to the number of admissions. Regardless of greater needs, hospital admissions are restricted to the most severely ill patients.

In Slovenia, there are one psychiatrist and 0.5 hospital beds per 10,000 inhabitants. Seventy-five percent of Slovenian psychiatrists are employed in hospitals, but at the same time they also work in outpatient facilities. Hospital admissions have doubled in the last ten years. According to the World Health Organization (WHO)'s guidelines, inpatient treatment of psychiatric cases should predominantly occur in general hospitals: however, the Slovenian general hospitals have a very limited number of beds available for this purpose. The availability of psychiatric treatment is not uniform: in the Ljubljana region there is one psychiatrist per 6,500 people, while in other regions lacking hospital facilities a single psychiatrist has to cover a population of 25,000. The problem is further aggravated by the fact that the regions with the lowest number of psychiatrists have the highest rate of people with severe mental disorders, which is evident from the suicide statistics (1).

The waiting time for outpatient psychiatric treatment in the central Slovenian region has been increasing, presently being 4 months on average. The access to psychiatric outpatient facilities, which used to be easy in the past even without referral forms, is becoming now increasingly difficult. Social and health care services work each on their own, in terms of both their approach to the clients and their education and training. Interdisciplinary issues, such as for instance psychosocial rehabilitation, are not included in any undergraduate training program, and cooperation between higher education institutions is modest. Education programs at the faculties of medicine, psychology and education and at the college of medical profession are not coordinated and do not contribute to improve the discriminatory attitude of students to psychiatric patients. Rather than program-oriented, the ideas about planning of mental health services are static and bound to the existing institutions.

We believe that under these circumstances it is necessary to enhance preventive activities, which may ensure timely and prompt interventions at patients' homes, as well as further treatment and continuous follow-up in the natural setting (home care, crisis intervention), as suggested in WHO guidelines. The most significant support in this respect can be expected from the rapidly developing private non-profit voluntary associations in the community. These offer their help with the organization of living and self support as well as some possibilities for training and employment. Some of them offer rehabilitation services in the regional centers throughout Slovenia.

Following Thornicroft and Tansella's model (2), it would be advisable to develop in Slovenia primary care units with specialist backup, flexible community mental health teams with case management and long-term community-based residential care, outpatient clinics, and mainstream mental health care, coordinated among them. Harmonization between health services, social services, housing agencies and non-governmental organizations (NGOs) is essential to ensure continuity and quality of care. However, planning of better coordination and availability of continuous and network-integrated activities of psychiatric services have not become a priority in Slovenia as yet. Rehabilitation services have started to develop in hospitals on the initiative of NGOs, which were the first to implement education programs for patients and their families, integrating them into the hospital setting.

Currently, the central Slovenian hospital is preparing new ways to keep record on services and planning of care after discharge. The standards of treatment are defined by different clinical approaches, intended for individual diagnostic groups of patients. These were prepared in order to ensure cooperation with the community services, assessment of patients' needs, individually adjusted treatment modalities and the participation of patients in the treatment and care. In the last months, we have obtained for the first time that some mental health teams perform part of their work at patients' homes. The stress laid on team work and shared definition of treatment objectives have brought about some objective results in chronically ill patients who were discharged to the community (3). Our partners in the implementation of rehabilitation programs are mainly non-profit voluntary organizations.

With the collapse of outpatient clinics due to service privatization, we tried to transfer part of treatment and care activities to general practitioners. However, they are often overburdened (each of them has an average of 1,800 patients) and thus not ready to take upon themselves the additional care of psychiatric patients.

Patients, and particularly their families, have great expectations about the new Slovenian mental health legislation that has been in the process of being adopted for almost a decade now. The law is supposed to be associated with a national program aiming to ensure that people with severe mental disorders have the same rights as other disabled persons regarding employment and social support. However, it seems that the law, which is being prepared at an inter-ministerial level, will in the first place sort out involuntary hospitalization procedures, and define some new personnel profiles for community monitoring and supervision.

The predominant concern is that the law will define certain rights without ensuring that they will be exercised in practice, since Slovenia lacks the human resources and the trained staff needed to implement supervision and support. The discussion about the law should be joined by psychiatric professionals, users of their services, and patients' families. The first round-table conference on the law was organized by the non-profit voluntary organization "ŠENT" in order to present the Helsinki Declaration (4), in which the promotion of mental health care, treatment and rehabilitation were set out as priorities by the WHO and its member states.

According to this Declaration, mental health policies, programmes and legislations should be established based on current knowledge and considerations regarding human rights, and people with mental health problems should be offered comprehensive care and treatment in a range of settings in a manner that respects their personal preferences and protects them from neglect and abuse. However, the overcrowded and ever less accessible hospitals and social institutions, with a personnel that is neither qualified nor ready for community work, cannot meet these requirements. Some advances may be seen only in the increasingly competent and demanding attitude of the users to our services, in the currently still isolated and non-regulated attempts to carry out community interventions, as well as in the pressure by NGOs to fight against stigmatization of people with mental disorders.

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Letter to the Editor

I read with great interest the special article on constructivism by Mahoney and Granvold in the June 2005 issue of World Psychiatry (1) and I would like to comment briefly on its implications for our conceptualization of psychopathological states.

Nowadays, professionals in psychiatry are mentally guided by the DSM system, which arranges psychopathological states into categories that tend to gain an independent raison d'être neglecting the symptom bearing subjects. Thus, the cross-sectional point of view is prioritised against the longitudinal approach, which puts its emphasis on the patient's individual biography.

The significance of the individual lifespan development was emphasised by the traditional, especially dynamic, psychopathological schools, and a revival of this approach can be noticed today at the international level. These shifts of psychiatric thinking remind us of the philosophical debate usually identified as the "universalia-dispute".

Do general notions have real existence or are they merely "names" ("nomina" in Latin or "mental constructs" as we prefer to call them nowadays)? According to the "realist" point of view, general notions exist independently from the real entities they denote ("universalia ante rem"). This concept springs from Plato, who attributed "real" existence to "ideas".

According to "moderate realism", instead, general notions do have real existence containing the essence of individual things, but they cannot be entirely abstracted from them. The general Being manifests itself consequently in the individual entities ("universalia in re"), but does not exist by itself.

The "antirealist" thinking goes back to Aristotle, and has subsequently developed into the "nominalistic" position, according to which general notions have no real existence, but are only names ("nomina"). The universality of things does not exist except in words ("universalia post rem").

It seems appropriate to analyse the diagnostic categories of psychiatry in the light of this medieval dispute. The impressive building of the latest diagnostic categories in psychiatry is nothing else than a modern system of "universalia" (general notions). It is obvious that the categories manifest themselves in the symptom carrying subjects; therefore, their independent existence ("universalia ante rem") can be disputed. Nevertheless, international research programmes, the clinical practice and the pressure performed by financing agencies force sometimes psychiatrists (the whole medical practice in a broader sense) to consider these categories as independent entities. Rather than adopting a "moderate realistic" view, we fall into the nest of the extreme realism. By performing further analysis on these mental constructs (diagnostic categories), we alienate them from the control of reality (the symptom bearing subjects), and we place them into an artificial, virtual world.

Constructivism is one of the approaches which are currently directing psychiatric thinking towards a more "moderate realistic" position.

László Tringer
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The 13th World Congress of Psychiatry, Cairo 2005: perspectives from the Secretariat

JOHN COX
WPA Secretary General

The Cairo World Congress was a truly remarkable one, and those who experienced the vibrant science, the ancient and modern of Egypt, and the vigorous election process, will have understood that the WPA is not only alive, but also kicking.

The Opening Ceremony, presided by Ahmed Okasha, was followed by a buffet in the Chinese Garden of the Congress Centre, where delegates were entertained by music and dance from Pharaonic times. The President's plenary lecture "Mental disorders and care in Egyptian history: from pharaonic to islamic eras" was a scholarly reminder to those who were not fully aware of the ingenuity of this remarkable civilization.

The new WPA President (Juan Enrique Mezzich) delivered an inspiring plenary lecture entitled "Science and humanism; the double helix of psychiatry". The WPA is leading a more total approach to the understanding of mental disorders, and the training of mental health professionals.

The Egyptian Psychiatric Association had worked with great energy to see that the local arrangements, including transport in rush hour, worked as smoothly as possible, and was a most generous host.

This was the first World Congress to be held in Africa, an event which fulfilled the dreams of many, and thwarted those who may have wished otherwise. Almost 6,000 psychiatrists attended from across the globe and particularly notable were the numbers of younger psychiatrists from Africa, Asia and the Middle East.

The Secretary General had little time to admire the scenery or, on this occasion, the ancient history, as there were meetings of the old and new Executive Committee, the old and new Board, as well as the Council and other Operational Committees. A record number of Member Societies, 107 of 129, were represented in the General Assembly.

It would seem that the energy from young psychiatrists, many of whom are active in research and audit, is vitalising WPA and keeping its older members young at heart.

The General Assembly was described as one of the best organised in the history of WPA, although a more contemporary voting procedure needs to be considered. This success at a time of transition of the Secretariat occurred through the strenuous efforts of administrators in New York, Geneva and Keele – helped a little by the Secretary General and our local hosts! Their commitment, nerve and sheer hard work was self evident and proportional to their considerable responsibilities. We will learn in future to make sure that the office environment for the administrators and delegates is more congenial, and that careful consideration is given to the possibility of electronic voting.

The General Assembly endorsed the Cairo Declaration on Mass Violence and Mental Health, established Task Forces on Practical and Ethical Guidelines for Elections, and on Causes and Consequences of Brain Drain, as well as approving several important consensus statements.

The formal minutes of the General Assembly are being agreed and will be placed on the WPA website.

Nine new Member Societies joined the WPA: the Algerian Psychiatric Association, the Ethiopian Psychiatric Association, the Irish College of Psychiatrists, the League of Mental Health from Republic of Moldova, the Mongolian Mental Health Association, the Palestinian Psychiatric Association, the Sri Lanka College of Psychiatrists, the Psychiatric Association of Turkey, and the Association of Psychiatrists of Uzbekistan.

The Saudi Arabian Psychiatric Association was welcomed as an ad-hoc Member Society.

The new Affiliated Associations are: the African Association of Psychiatrists and Allied Professions, the Indo-Australasian Psychiatry Association and the Australasian South Asian Psychiatry Forum, the Mental Health Care Organisation of Uganda, the Psychiatric Association for Eastern Europe and the Balkans, and the South Asian Association for Regional Cooperation (SAARC).

The Assembly gave a standing ovation to the President Ahmed Okasha at the end of his term of office, acknowledged fully the major contributions of retiring Executive Committee members (George Christodoulou and Roger Montenegro) and applauded enthusiastically the election of the new President Elect Mario Maj, as well as those of the new Secretary for Publications Helen Herrman, the new Secretary for Sections Miguel Jorge, and the new Secretary for Education Allan Tasman.

The new President Juan Enrique Mezzich was inducted and then introduced the new Executive Committee and the new Board. He gave an inspiring vision for the next three years with an emphasis on institutional consolidation and the promotion of integrative psychiatry – a psychiatry for the person.

The past and present had therefore met in Cairo at the crossroads of the world, and many delegates left Egypt with a greater sense of international solidarity, as members from small societies enriched those from larger organisations. At the Congress the Asian Federation of Psychiatry was launched and the energy of our colleagues in Asia was tangible.

The human resources and proceedings of this World Congress, the first held in Cairo on the Nile, may it is hoped now travel vigorously up-river (like a Scottish salmon) to that culturally rich sub-Saharan region of Africa where African psychiatry and psychiatrists (conspicuous at the Congress) also flourish, and yet patient care is still so much in jeopardy.

The WPA Cairo Declaration

Ahmed Okasha
President, 13th World Congress of Psychiatry; WPA Immediate Past President

Two months before the 13th World Congress of Psychiatry (September 10-15, 2005), we had two terrible terrorist attacks in London, followed by one in Sharm El Sheikh. The Organizing and Scientific Committees of the Congress were not intimidated by such attacks and did not yield to their goals. The solidarity of the WPA Member Societies and of our colleagues in the psychiatric field enabled us to continue our work.

The 13th World Congress of Psychiatry had more than 5,600 participants from 119 countries, including 15 from Africa. In the WPA General Assembly, 107 Member Societies were represented (a number never reached before). The scientific programme of the Congress included more than 3,500 papers and more than 250 symposia.

We decided to address the issue of mass violence and mental health in a special Declaration. This document, produced by a Task Force and revised by the WPA Executive Committee, Council and Board, was approved by the General Assembly on September 12. Here you can find the final text.

WPA CAIRO DECLARATION ON "MASS VIOLENCE AND MENTAL HEALTH"

The General Assembly of the World Psychiatric Association:

- emphasizing that the World Psychiatric Association, being the world's largest psychiatric association, comprising 130 Societies from 113 countries, can speak on behalf of 175,000 members of the profession;
- conscious of the fact that violence is a major public health problem with important mental health implications;
- concerned by the fact that mass violence such as war, terrorism, urban violence and similar acts causes many deaths, material losses and mental health problems in the lives of the survivors and in the population at large;
- cognizant of the fact that violence does not help to solve problems but begets violence and brings with it poverty, hunger, disease and fear;
- underlining that, unless properly addressed, the psychosocial consequences of violence will negatively affect future generations and can destroy the social cohesion that allows people to live together in harmony;
- convinced that psychiatry and behavioural sciences can contribute to the understanding of the complex biological, psychological and social roots of violence and to the formulation of interventions that can prevent violence or alleviate its consequences;
- recalling previous work of the World Psychiatric Association on alleviating consequences of disasters and the prevention of mental disorders;
- recognizing that terrorism, by itself, is not a mental illness but a phenomenon often associated with oppression and absence of opportunities for free expression or redress;
- considering that the alliance of mental health workers and leaders of religions that advocate mercy, compassion and forgiveness might help in the prevention of violence and in the alleviation of its consequences.

Urges the WPA Member Societies:

- to develop and support research on the causes and consequences of violence and develop training programmes that will help in the prevention of violence and in helping its victims;
- to invite their members to cooperate with other professionals and all those who are working for peace without any ideological or other prejudice.

Requests the Scientific Sections of the WPA to develop collaborative and multidisciplinary research on the origins of violence.

Requests the Executive Committee of the WPA to:

- find ways to effectively collaborate with governmental and other agencies in the prevention of mass violence and the alleviation of its consequences;
- invite the World Health Organization to strengthen its efforts to enhance the awareness of the public health importance of violence and to convey to its Member States the need for research and action in this area;
- undertake whatever is necessary to ensure that the scientific knowledge stemming from psychiatry and neurosciences and behavioural sciences is used in dealing with problems of violence;
- create a special programme on mental health aspects of violence to facilitate the above tasks and further stimulate research and action in this area of its work;
- report on the steps taken in response to this declaration at the WPA General Assembly in 2008.

WPA financial report

Sam Tyano
WPA Secretary for Finances

This report presents the results of three years of work of a newcomer to the WPA in the position of Secretary for Finances, supported by a Finance Committee whose members were R. Astill, R. Cancro, M. Kastrup, O. Ray and K. Yamazaki.

When the Finance Committee started its work, it was clear there were only two months of functioning funds left in the bank. We had to establish two different kinds of action: a) an emergency plan in order to survive; b) a financial policy in order to ensure a long-term solid financial base.

The facts we had to translate into action were: a) to retrieve money from previous congresses (in particular, the 11th World Congress); b) to start negotiations with the pharmaceutical industry in order to create a Corporate Supporters Programme (this programme guarantees the pharmaceutical companies their participation in the next World and International Congresses, by paying their financial contribution three years in advance, and allows the WPA to have resources available between the congresses); c) to accommodate expenses according to income; d) to create a reserve corresponding to one year expenses; e) to participate in the preparation of all contracts and congress budgets negotiated by the WPA and its components in order to offer expertise and advice to reduce superfluous expenses. Once the WPA Executive Committee had agreed on these main points, we were able to move on.

Our income has increased from 501,624 US$ in 2002 to 804,356 US$ in 2003, 1,154,497 US$ in 2004 and 921,700 in 2005 (predicted). Our expenses have remained stable from 2002 to 2004 (456,063 US$ in 2002, 459,416 US$ in 2003, 479,856 US$ in 2004) and only increased in 2005 (811,000 US$), when we had to allocate some funds for the opening of the permanent secretariat in Geneva and the actual transfer of our office from New York to Geneva. Moreover, we have created a reserve corresponding to one year expenses.

Looking into the details of the sources of income, retrieving money from the previous World Congresses was of great importance (income of 288,124 US$ in 2003 and 503,500 US$ in 2005). Equally important was the success of the Florence International Congress (income of 504,412 US$). The Corporate Supporters Programme generated an income of 230,000 US$ in 2003, 220,000 US$ in 2004 and 220,000 US$ in 2005.

Concerning the expenses, we have neither increased the expenses for the Executive Committee, nor our office expenses except for the transfer to Geneva. We could allocate some funds for the training of professionals after the Tsunami disaster, and offer increased financial support for research to zone representatives and Sections' chairpersons.

Unfortunately, we do not have any educational programmes in sight which would generate income; therefore, our resources will decrease accordingly during the next two years compared to the previous period.

Although we feel somewhat relieved, we are still concerned and we do not yet see: a) how to lead the WPA into having its own independent financial system; b) how to secure our own resources, in order to be independent from external funding (specifically, support by the pharmaceutical industry, which is starting to be limited due to guidelines and ethical considerations); c) how to find different solutions to grant support to our WPA Member Societies and officers to provide bigger and better opportunities for research and training programmes. These are the main goals which we will focus on over the next three years.

The International Consensus Statement on Women's Mental Health and the WPA Consensus Statement on Interpersonal Violence against Women

Donna E. Stewart

University Health Network Women's Health Program, University of Toronto, Canada

In 1999, women's mental health leaders from Europe, Asia, Africa, North and South America and Australia began a fact finding process to determine the psychosocial, cultural and environmental factors which were most salient to women's mental health and mental illness. At the 2001 First World Congress on Women's Mental Health in Berlin, they rank ordered these factors. Discussion among women psychiatrists, psychologists, social workers, mental health nurses, policy experts, non-governmental organizations (NGOs) and consumers resulted in a published summary (1).

In 2003-2004, further discussions were held that culminated in a March 2004 roundtable at the Second World Congress on Women's Mental Health in Washington, sponsored by the International Association for Women's Mental Health. A decision was made to develop an International Consensus Statement on Women's Mental Health that described the issues and concluded with recommendations.

A Consensus Statement on Interpersonal Violence against Women was also written by the WPA Section on Women's Mental Health, and submitted to the WPA Executive Committee and Member Societies for their comments.

Work on the International Consensus Statement on Women's Mental Health was further facilitated by a WPA meeting at Metropolitan Hospital in New York City in April 2004 and a subsequent meeting hosted by the American Psychological Association in September 2004. This International Consensus Statement on Women's Mental Health was approved by the American Psychological Association and the American Psychiatric Association by December 2004 and then rapidly approved by a number of national mental health associations, NGOs and individuals. Both the International Consensus Statement on Women's Mental Health and the Consensus Statement on Interpersonal Violence Against Women were approved by the WPA at its General Assembly in Cairo in September 2005.

We urge all WPA Member Societies to disseminate these Consensus Statements by posting them on their websites and distributing them to their members, in their journals and other written communications. Even more importantly, we urge WPA Member Societies, individual psychiatrists and other mental health workers to begin work to implement the recommendations to improve women's mental health. Please let us know how we can help (donna.stewart@uhn.on.ca).

INTERNATIONAL CONSENSUS STATEMENT ON WOMEN'S MENTAL HEALTH

Preamble

The 1995 United Nations (UN) Beijing Platform for Action states that "Women have the right to the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and wellbeing…" (2). In September 2000, UN agencies, 189 member countries of the UN, as well as multilateral and bilateral agencies unanimously endorsed the Millennium Declaration (3). The Millennium Development Goals, made up of 8 Goals and 48 Targets, are recognized as the road map for implementing the Millennium Declaration. The Goals include the achievement of universal primary education, the promotion of gender equality, reduction of child mortality, improving maternal health and combating HIV/AIDS, among others. Mental well-being of the mother is integral to the health, nutrition and educational outcomes of their children, violence against women erodes gender equality and the empowerment of women, as well as putting women at increased risk for HIV infection. It is thus imperative that women's mental health be prioritized, if the Millennium Development Goals are to be achieved.

Women's mental health must be considered within the context of women's lives and cannot be achieved without equal access to basic human rights: autonomy of the person, education, safety, economic security, property and legal rights, employment, physical health, including sexual and reproductive rights, access to health care, and adequate food, water, and shelter. Women's mental health requires the elimination of violence and discrimination based on sex, age, income, race, ethnic background, sexual orientation or religious beliefs. While both sexes benefit from the above factors and the overall rates of mental illness are similar in men and women, women's unique roles in reproduction, the family and society, and their often lower socioeconomic status, necessitate special considerations for their mental health.

Even in optimal circumstances, some women will experience mental health problems and illnesses for which adequate diagnosis and treatment are essential. The identification of women's mental health problems should ideally start with women themselves who should be provided with accurate, understandable information about mental health, psychological distress, illnesses, and available services and treatments. Evaluation of mental health problems in women must consider the full context of their lives, as distress in women often has social origins and diagnoses should not be stigmatizing. The role of violence and discrimination in the genesis of mental health problems in women requires special consideration. Social and psychological services and primary care physicians should be able to undertake evaluation, diagnosis and treatment or offer referral to appropriate specialty services. Women should have access to respectful, knowledgeable mental health care in a timely fashion, in a nonstigmatizing, suitable setting within their economic means, by adequately skilled health professionals with access to appropriate treatments.

Treatment settings should be safe, and free from breaches of fiduciary trust by health care providers and staff. Women's preferences for informed medical decision making should be respected whenever possible, and the quality of care should be assessed by indicators that are consistent with best current knowledge, informed by gender-sensitive research. Women who have been sexually abused, or who have strong preferences for female health care providers, should be accommodated whenever possible. Appropriate services for adolescent, peripartum, midlife, older, immigrant, refugee, disabled and incarcerated women are essential. Acute and continuing care, supportive and rehabilitative mental health services across the life span are essential to enable mentally ill women to achieve their optimal level of functioning and well-being. Positive women's mental health benefits the health of women themselves, their families, and the general population and promotes women's participation in professions and leadership.

Recommendations

Accordingly, we recommend that professional mental health and health organizations and providers, governments, the UN system, the World Health Organization, other international health and social organizations and appropriate nongovernmental organizations integrate girls' and women's mental health as a priority in policy and program development and…

- Support psychological health promotion programs that encompass the life context of girls and women to include equal access to basic human rights, education and employment, the elimination of violence and discrimination and the reduction of poverty.
- Support women's marital, sexual and reproductive choices and ensure access to safe motherhood.
- Support public education and awareness campaigns that increase recognition and reduce the stigma of mental illness in girls and women.
- Support safe, respectful, appropriate, gender sensitive comprehensive mental health and physical health services for girls and women across the life cycle irrespective of their economic and social status, race, nationality or ethnocultural background.
- Support timely access to adequately skilled mental health professionals who provide quality of care consis-

tent with best current knowledge and availability of appropriate therapy, technology or drugs and who take women's special needs into consideration.

- Support the development and use of culturally appropriate diagnostic systems that consider the sociocultural context of women's lives, and biological differences when they are salient.
- Support the provision of accurate information and respect choices in treatment decision making by girls and women whenever possible.
- Support the provision of mental health care for girls and women that is free from breaches in fiduciary responsibility.
- Support increased attention to research on girls' and women's mental health including those factors which enhance or inhibit the development of resiliency.
- Support the provision of core training and education about gender issues for health, and mental health, professionals.
- Support gender equality in practice and promotion within mental health services and organizations including equal opportunities for advancement and eradication of gender harassment, intimidation or unjustified discrimination on the basis of sex.

WPA CONSENSUS STATEMENT ON INTERPERSONAL VIOLENCE AGAINST WOMEN

Interpersonal violence is a critical public health challenge throughout the world that causes distress, reduced quality of life, physical and mental health consequences, and even death (4,5).

Although men, women and children may all be victims of violence, the perpetrators and consequences of violence are usually different for men and women. While men are most likely to be injured by strangers during the commission of a crime, or in war; women are most likely to be injured by their male partners or other family members; often someone they live with and love. In fact, women are more likely to be murdered by their intimate partners than by strangers. In addition, men's greater size and strength, and their more frequent use of weapons, result in more serious injuries to women from interpersonal violence between men and women (6). All these differences require special consideration for prevention, amelioration and policy for each gender, and accordingly, this consensus statement has been developed on interpersonal violence against women.

Research reveals a high prevalence of acute and chronic physical and mental health consequences of violence against women. Women who are victims of violence are more likely to suffer from depression, anxiety, post-traumatic stress disorder, borderline personality disorder, substance abuse, sexual dysfunction, low self-esteem, and psychological distress, as well as a host of acute and chronic physical disorders. Violence and abuse in early life are strong predictors of later mental illness, especially depression. Moreover, being assaulted, or witnessing an assault on family members in childhood, or adolescence, increases the risk of mental disorders, low self-esteem and subsequent involvement in abusive relationships for both men and women. Violence against women also has negative secondary effects for families, communities, society and the economy (4-9).

Violence against women takes many forms: battery, sexual assault, psychological abuse and harassment. Cultural norms, social expectations, and gender roles and relations may promote such violence against women and these social forces may determine the consequences to the woman and the response of society. Media and advertising too often portray violence against women as acceptable. Although religion may be used as a rationalization for violence against women, reference to core religious documents, such as the Bible, the Koran and the Torah, reveal in many parts that violence against women is not acceptable (4-9).

Understanding male violence against women requires an examination of the physical, legal and economic power inequality between men and women. Poor and older women, mentally ill women, women with disabilities, women in institutions, ethnic minorities, sex workers, trafficked women, and other disadvantaged women, including women during armed conflict, are all disproportionately at risk for violence (7,8).

As psychiatrists and other mental health professionals play vital roles as mental health care service providers, educators, researchers and policy advocates, who help shape mental health professional practice and public opinion, be it resolved that the World Psychiatric Association:

- Issue a policy statement that recognizes violence against women as a major determinant of mental distress and psychiatric illness in women and strongly condemns all forms of violence against women.
- Support programs to improve the education of practicing and training psychiatrists to recognize and treat victims of violence. This education should include, as a starting point, the routine inquiry about violence and victimization in all psychiatric assessments, the recognition of the role of violence and rape in the genesis of many psychiatric illnesses and as a treatment issue.
- Promote safe, respectful, non-blaming, ambulatory and inpatient treatment programs for women victims of violence.
- Support research to develop and evaluate the best treatments for women who have suffered from violence, and for their children and the perpetrators.
- Support health professionals' and public awareness of violence against women as a critical women's mental health determinant.
- Explore opportunities for greater interprofessional collaboration (legal, social, medical, and policy makers) on an international level to prevent and ameliorate violence against women, including violence during armed conflict.
- Explore wide ranging psycho-educational and socio-cultural interventions designed to change the objectification

of women, which is a major determinant of violence against women.
- Censure public statements which seek to normalize violence against women as acceptable or a cultural norm.

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The WPA Regional and Intersectional Congress "Advances in Psychiatry"

AHMED OKASHA
President of the Congress

This congress, held in Athens (March 12-15, 2005), was unprecedented for a variety of reasons. First, it was the first intersectional congress in the history of the WPA: practically all Sections participated with update talks, symposia, courses and intersectional presentations. Second, it was the first electronic congress of the WPA, with virtual proceedings, i.e. power-point presentations (author-authorized) in the WPA website. Third, although the congress was regional, yet it had a worldwide range: representatives of as many as 73 countries participated.

The scientific program included presentations that represented advances in our discipline. There were, among others, invited update talks by the (now 64) WPA Section chairs and invited talks by eminent psychiatrists.

The congress hosted two important groups. The first was that of the leaders from the areas hit by the South East Asia Tsunami, convened to make important decisions concerning the management of the psychosocial effects of this disaster. The second was the group of the leaders of the psychiatric associations of Eastern Europe and the Balkans, who met to approve the constitution of the new Psychiatric Association of Eastern Europe and the Balkans.

Many innovations characterized the congress. A forum on advances in psychiatry, an intersectional forum on disasters, an intersectional forum on psychiatric prevention, a forum on mental health promotion (with the participation of educators, priests, judges, journalists, police officers, general practitioners and other community allies), the young psychiatrists' forum, and a spectacular opening in the presence of the Greek Minister of Education and the Archbishop of Greece, with well-received talks by the WPA President and President-Elect and a performance by the Mikis Theodorakis orchestra. Additionally, a mini-marathon race was organized, as well as a cruise to the historical islands of Hydra and Egina. Also, about 110 persons, mainly representatives of WPA Sections, were covered financially, wholly or partly. In spite of this, the congress provided some income to the WPA, a rare occurrence for a regional congress.

We feel sure that the congress greatly contributed to the dissemination of updated scientific information in our discipline. More than that, however, it enhanced the morale and the visibility of our Sections, the "scientific backbone" of our Association.

We shoud congratulate George Christodoulou for his effort to make this event unique and successful. We feel confident that, following the great success of this congress, further intersectional congresses will follow in the not too distant future with the same success.

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