Psychiatric treatment with people displaced in or from fragile states

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A fragile state is not an ideal environment for any professional to work within – psychiatric, medical or otherwise. Psychiatrists working to assess psychological distress and mental health in fragile states, or with refugees from fragile states, need to adopt flexible approaches.

The instability and uncertainty usually found in fragile states create a breeding ground for psychological problems and mental health issues, as well as risk of physical harm. Individuals that live in such environments are more likely to experience trauma on a scale not otherwise known by the rest of the world. When deciding how best to adjust practice and treatment when working with those from fragile states, the psychiatric community must be able to examine many aspects of the environment surrounding that particular social group.

The circumstances under which the psychiatrist is operating may well dictate what work can be delivered. Teams of researchers and psychiatrists often descend to determine the levels of psychological distress and look at mental health issues and can be faced with a range of restrictions including general health treatment limitations, inability to adopt a multidisciplinary approach and reduced access to psychotropic medication and other drugs. Traditional methodologies therefore need to be adjusted in this environment, first of all by taking into consideration which treatment plans can realistically be considered.

Within refugee camps or safety zones with basic living conditions and little apparent governance or control, violence can occur without warning, services may be attacked or cut off from outside assistance, political and economic disruption may occur and governmental policy could change at any time. Although short-term and intensive cognitive behavioural therapy sessions – usually used once the immediate distress of the patient has been alleviated – have been successful within Western and refugee populations, it is unknown whether the same success rates can be repeated elsewhere. In spite of this, short-term interventions may be the best way forward as they will empower the individual and give them tools to help themselves if psychiatrists are no longer present.

Many attempts have been made to design psychiatric assessment questionnaires and scales that are sensitive to different cultures and that include colloquial terminology and phrasing. Unfortunately, when a team is dispatched in an emergency situation, the likelihood of obtaining an already validated set of assessment tools is low. This is a considerable barrier for psychiatric professionals to overcome. Bringing an additional person into the assessment or treatment stages to act as translator may cause confidentiality issues but alternative options are limited. The use of local bilingual professionals and volunteers may help psychiatrists assess which diagnostic tools will be efficient, and they may even be involved in the treatment process.

Every psychiatrist must be able to provide care that is free from discrimination of any kind; the psychiatric community may, however, hold preconceptions about certain social groups. It has been noted, for example, that the role of women during times of conflict has been described almost exclusively in relation to victim status. Although women are at a higher risk of being the targets of persecution and acts of violence, the psychiatrist could be at risk of viewing all female patients as victims, and not, as was the case during the 1994 Rwandan genocide for example, as perpetrators, instigators or bystanders.

Cultural interpretation and understanding

Psychiatrists may not be able to view such vulnerable groups outside their own, traditional and often Western points of view. The structure of family units, gender roles and class systems differ with every culture, and are also more likely to be going through a state of flux within fragile states. All these factors may lead psychiatrists to misinterpret symptoms or make incorrect assumptions regarding their causes. Traditional treatment methods should be adapted; for example, children and adolescents may not benefit from therapy designed for their age groups as they face living situations that are drastically different from those of Western children and children living in stable environments.

People in fragile states may have their own, often supernatural, explanations for common symptoms. These may be similar to those experienced by Western civilian populations (e.g. headaches, chest pain or disturbed sleep patterns) but are instead associated with illnesses not formally recognised by psychiatric professionals. Patients should not be discouraged from using more holistic and local traditional methods if they so wish, as long as they do not clash with the treatment provided by the psychiatrist; this will help preserve their identity and cultural attachments as well as boosting morale.

Psychiatrists may also have to refer back to basic psychological theories such as Maslow's Hierarchy of Needs which requires that, before the psychiatrist begins to treat problems such as depression, anxiety and possible post-traumatic stress disorder, they must first be able to ensure that the patient's basic needs are being met.[1]

The psychiatric community must be sensitive to the difficult working conditions; traditional ways of operating and conducting treatment may not be efficient. Emphasis should be placed on multidisciplinary approaches even although achieving this within fragmented societies will be difficult. Following up on patients could be rendered impossible, and individuals could be left with limited or a complete lack of professional psychiatric support.

Rather than simply delivering treatment, the psychiatric community should look at alternative approaches. While current research is calling for more long-term treatment approaches in these settings, it perhaps should not be delivered by international psychiatrists; local NGOs and professionals could instead be trained in psychological care. This way, when external organisations leave, treatment and psychiatric care can continue where needed.

Working with people displaced from fragile states

Although many of the above factors are still relevant issues for psychiatrists operating outside a fragile state, new obstacles arise when those who are displaced seek refuge and psychiatric treatment in a different country.

Having experienced maybe long and often dangerous journeys to a place of refuge, individuals are then likely to enter the asylum process where they face further anxiety and uncertainty regarding their future. The psychiatrist who treats patients at this stage faces many practical issues even before assessment can begin. Medical histories may either be inaccessible or non-existent. There are likely to be social barriers between the psychiatrist and the patient, even more so than if the psychiatrist were operating within the fragile state itself. The psychiatrist is less likely to speak the language of the patient, and may have a limited understanding about – and no easy way to find out about – the history and culture of the fragile state from which the patient has fled. This will cause difficulty when trying to build a picture of the patient's history and past experiences, as well as when analysing symptoms and making formal diagnoses.

This period of uncertainty for the patient may coincide with difficulty in meeting basic physical needs that are higher up in Maslow's Hierarchy and thus are still a priority. The patient may also be experiencing psychological disturbances as a result of

external events which the psychiatrist has little awareness of or understanding about, and that may not be easily addressed in the course of treatment that is delivered. For example, some asylum seekers and refugees are uncertain about the fate of their loved ones, and may fear that harm or injury has befallen their family in their home country. They may have pressure on them to provide for those that have been left behind, and may be unaware of current events in the country that they came from. The fact that they have no control over their return to their home country, whether it is wanted or not, can make the person feel as though they are in a state of limbo, with no control over their fate.

The psychiatrist may not be given a definite period of time to work with their patients, and instead may have to adopt more intensive treatment models. Although it is difficult to prepare for such changes, better communication across multiple disciplines and organisations handling each case could reduce the risk of increasing psychological distress in the future. If a psychiatrist working with a refugee during the asylum process, for example, is able to build up an extensive medical history of the patient, as well as making a formal diagnosis and treatment plan, and if the patient's application is successful, these notes could be passed on to the appropriate authorities such as general and mental health service providers, as well as local housing authorities or social services.

Once the displaced individual has found a stable form of refuge and has begun resettlement, psychiatric care can move into a different stage. Problems that affect the general population will now begin to affect the displaced individual. These will be on top of other problems such as integration into society, learning a new language, dealing with past traumatic events, uncertainty about the safety of loved ones back home and regaining a social status similar to that they achieved in their home country; all of these issues have been found to cause additional psychological distress in refugee populations. Not every psychiatrist will have the social or practical tools readily available to deal with such problems; they should instead be encouraged to signpost the patient to partnering organisations and service providers such as social services, community centres and help groups. What the wider psychiatric community can provide, however, is basic training and skills that can be used when assessing and treating individuals from backgrounds such as these. People coming from fragile states are more likely to have experienced or witnessed an act of violence or traumatic event. Patients may be reluctant to divulge information regarding events such as these; therefore extensive notes formed by other professionals as part of a multidisciplinary and collaborative approach could be extremely useful.

Conclusion

Whatever the context, the decision over whether to address short-term or long-term needs of those from or displaced within fragile states may prove the most difficult for the individual psychiatrist. While organisations both within low- to middle-income countries and developed Western contexts roll out psychological care on a mass scale, a more structured and tailored approach is essential when working with patients from fragile states.

Amidst the instability there is a great opportunity for the wider international psychiatric community to learn and grow. Western-based psychiatric research is very limited in its scope and may only be applicable to those living within the contexts from which theories were derived. By working with individuals outside these contexts, psychiatrists are able to develop a view on how robust these theories really are and whether or not they can be generalised to other communities.

Knowledge is being gained about folk illnesses, differences in symptomatology, treatment methods and the effects that culture has on the way psychiatric illness is perceived. This knowledge is allowing the field of

psychiatry to become more relevant and reliable; it is also highlighting the malleability of current models and commonly held beliefs about the nature of the human psyche. By taking on a more collaborative approach, the international psychiatric community will be able to take these developments further and be enabled to provide assistance to those affected by the realities of living in or coming from fragile states in conflict.

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1. See http://en.wikipedia.org/wiki/Maslow's_hierarchy_of_needs