Mental health in the Syrian crisis: beyond immediate relief

According to the UN High Commissioner for Refugees, the number of registered Syrian refugees in neighbouring countries has surpassed 4 million, and more than 8 million people are internally displaced in Syria.

In this conflict, efforts and mental health research thus far have either focused on post-traumatic stress disorder (PTSD) spectrum illnesses or psychosocial support. This focus on PTSD and interventions to address immediate traumatic reactions means that efforts towards recovery and resilience, and prevention of long-term manifestations of trauma, do not exist. Such long-term and transgenerational manifestations can include severe and complex traumas, and exacerbations of pre-existing mental disorders, such as mood and anxiety disorders, psychoses, and substance use.1

An International Medical Corps report2 from clinics treating Syrian refugees reported high numbers of psychotic illnesses and non-PTSD presentations. Sóuabíyh Lame and colleagues3 compared rates of admissions of Syrians into Lebanese psychiatric hospitals before and after the war, and reported that hospital admissions for psychosis and suicide had substantially increased after the beginning of the war. Our own experience (HJ-B and AB-O) with the Syrian Telemental Health Network, which provides health consultations to health-care providers inside and outside Syria, gave similar trends. Two-thirds of all cases fit the severe emotional disturbance (including depression and anxiety) category, with most experiencing onsets before, and exacerbations during, the war.

Most individuals exposed to trauma recover within the first year of exposure if safety and stability conditions are established. Steel and colleagues4 reported that trauma-related mental illness reduced steadily over time among resettled refugees, with the exception of people with a high degree of exposure to trauma, who had long-term psychiatric morbidity.

Although efforts are understandably focused on training of staff and community members to recognise acute mental health symptoms, use psychological first aid, and establish referral systems into specialist care, the specialty needs to expand to include community-based and culturally sensitive programmes that enhance functionality and coping strategies of affected populations and protect future generations.

Long-term programmes should target pre-existing mental health issues, vulnerabilities to war-related experiences, and, most importantly, resiliency factors and functional capacity. After establishing what people need in community-oriented and collaborative ways, efforts should support individuals to restore relationships, build new, healthy patterns of interaction, and develop coping strategies. Creativity-based group programmes using the arts, such as theatre, singing, drawing, or writing poetry, might play a part, and centres designed to attract people with social events, workshops, groups, and other recovery-oriented activities can be used. An example is Antigone of Syria, a Lebanon-based theatre project, in which Syrian refugee women take part in workshops and produce a play, with objectives of empowerment, and support of their healing process by rebuilding communication and interpersonal skills.

Recovery-oriented programmes could provide community and family-focused psychosocial interventions (vocational, counselling, supportive trauma-focused help, etc) in addition to culturally sensitive psychoeducation. This education would aim to increase understanding of symptoms and treatability of trauma effects and complicated grief, and reduce stigma. Such an approach is especially important because it supports the objectives of the WHO Mental Health Action Plan 2013–2030 in creation of “comprehensive, integrated and responsive mental health and social care services in community-based settings”.3

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Medical leadership—from inspiration to education

In his Offline, Richard Horton (July 11, p 120)1 draws attention to the unmet need for leadership acumen within the medical profession. He attributes the challenge to a tendency to focus on fixing leadership weaknesses...
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rather than developing strengths. Playing to an individual’s strengths, he contends, is more likely to result in inspirational leadership. And while Horton rightly argues that accentuating one’s strengths is a good strategy, he stops short of advocating for widely cited competency models now used to design curricula in health leadership.

In 2014, an influential European Union health policy event—the European Health Forum Gastein—ended with a call for the “development of the right sort of leadership” in health care. Indeed, everybody can be a leader, if the right competencies are developed. But how?

The change should start with education. Whereas some authors call for talent identification, Czabanowska and colleagues propose a competency-based approach. Various models exist and share similar categories into which skills, abilities, and knowledge are grouped. Systems thinking, political leadership, organisational learning, communication, and emotional intelligence are among the domains. Application of problem-based learning at all levels of professional development programmes reinforces how leadership development works best from an experiential perspective.

Are we satisfied with the present placement of health in the policy environment? Probably not. The future of medical leadership—with implications not only for individual care, but also for population health—depends on our ability to effectively produce our future health leaders.

We declare no competing interests.

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