Taking measure of war trauma

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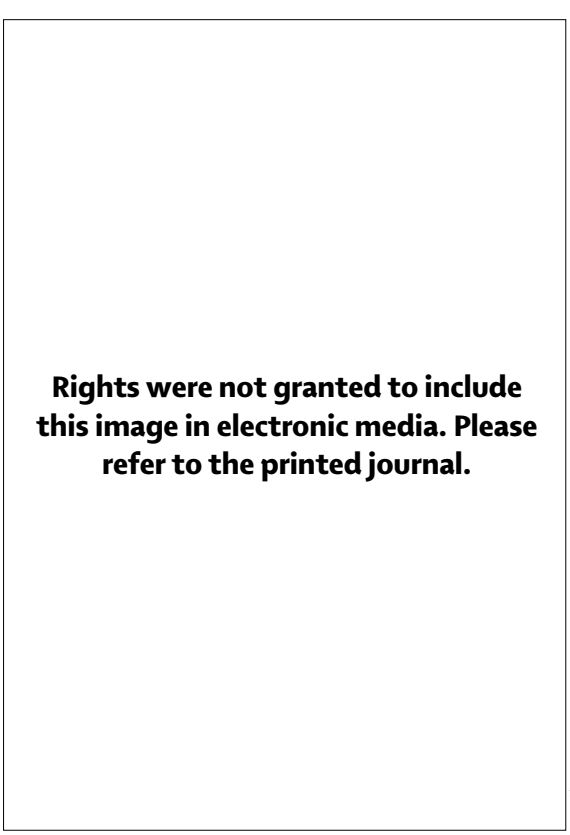
The article by Mina Fazel and colleagues in this issue of *The Lancet* adds to what is known about mental disorders in refugees resettled in western countries. Psychiatric illness might not be as prevalent as we have been led to believe by existing studies using various different methods. Furthermore, the investigators identified contextual variables that account for some of the heterogeny of prevalence rates in previous studies. The variability caused by these contextual factors is not small. For example, the reported prevalence of post-traumatic stress disorder is 218% higher when non-random samples are used (versus random or complete samples), 288% higher when patients are assessed through an interpreter (versus an interviewer who speaks their language), 322% higher when sample size is small (versus large), and 411% higher when clinical assessment is used (versus a semi-structured interview).

This information warrants attention by investigators, funding agencies, and service organisations. As world conflicts march on, people will probably continue to be traumatised and displaced. Because resources for science, policy-making, and services for refugees are scarce, it would be wise to ensure that data collected to make inferences, policies, and services are sound. In addition to using standard methods, better instruments need to be developed and used to measure trauma and health of refugees.[1] No empirically developed instruments have been published that adequately assess the broad range of trauma experiences and symptoms in community samples of refugees. Post-traumatic stress disorder might not be the most appropriate illness construct for traumatised refugees with multiple symptoms, because culture, language, and polytrauma complicate illness experience and diagnosis.[2] Furthermore, there is a lack of research about how events not related to conflict also cause distress and illness in refugees.[3,4] In some respects, our humanism has swayed our science. We have rushed to assess trauma and health, in part because of our reasonable outrage at the human proclivity to war and harm, without proper and standard tools for the job.

The corollary to modest rates of psychiatric illness is, as detailed in Antonovsky's work with Jewish survivors of the Holocaust,[5] that the capacity for the human mind and body to resist illness in the face of severe trauma is remarkable. That 10% of refugees have post-traumatic stress disorder is significant and should not be minimised. However, it means that 90% do not. The strength and resilience of refugees is understudied and needs to be honoured. With emerging evidence about the effect of adverse life events on many aspects of health,[6] it is important to know how some who are harmed escape these deleterious effects to see whether these protective factors can be promoted as preventive and treatment measures.

Although measuring trauma, resilience, and health outcomes in refugees is difficult and needs improvement, the investigators' data imply a more critical message, even if it is obvious and seems a bit glib: war and oppression cause individual and collective harm. At least 3–4 million of the roughly 37 million displaced people in the world[7] have psychiatric illness, and trauma exposure is the most important predictor of mental health status.[8] Refugees also probably have more medical illness.[9] This health burden does not even account for the undocumented number of non-



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displaced people exposed to the pathogenic effects of war, nor for the brave military personnel who are asked to participate in building a war machine that might later hurt them. The adverse effects of displacement alone on psychological wellbeing is well documented.[10,11] Refugees lose their place, and along with it parts of their identity, status, meaning, and capacity to support themselves and their families.[12,13] Countries such as Vietnam and Iraq have lost some of their best and brightest, who nonetheless have a major struggle to realise their full potential in their new domiciles. The world loses culture when dominant countries export their views and countries lose historical artifacts, highlighted recently by the destruction of ancient sites in Iraq.[14] The economic cost to individuals and societies is staggering and immeasurable.

Although the resiliency of refugees needs to be validated, more prevention and treatment are also urgently needed. A minority of the 3–4 million refugees with psychiatric disorders in the west can access care, and the percentage of internally displaced people who are served is probably even less. The social and economic burden for countries that have refugees is overwhelming. Sadly, much of this illness and distress is preventable. We could work with more resolve to prevent the harms of war. If we do not have the capacity to prevent war, we have a collective responsibility to better understand and treat its psychiatric, medical, and social consequences.

Michael Hollifield

University of Louisville Department of Psychiatry and Behavioral Sciences, Med Center One, Louisville, KY 40202, USA
m.hollifield@louisville.edu

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Control of suffering on the slippery slope of care

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What leads us to change our minds?[1] Reading the two reports in today's *Lancet* by Veerle Provoost and Astrid Vrakking and their respective colleagues in Belgium and the Netherlands about decisions on end-of-life care for infants, I wondered what if anything their information should do to my views about euthanasia. The findings from the two studies largely corroborate each other, albeit with slightly different evidence and emphasis. The survey of Flemish physicians who supervised the care of infants who died during 1999 and 2000 estimated that 57% of deaths were preceded by an end-of-life decision. These decisions involved withdrawing (21%) or withholding (13%) treatment, administering drugs to alleviate pain in doses that might have shortened life-span (16%), and purposefully administering a lethal dose of a drug (7%). When the physicians in this survey were questioned on their attitudes about the care of critically ill and dying infants, 68% affirmed that they would be willing to shorten the duration of terminal suffering of a neonate by using lethal drugs, and 88% agreed that considerations about a newborn infant's expected quality of life can be taken into account in therapeutic decision-making. The study of Dutch physicians who had cared for dying infants in 2001