

# Violence and mental health

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According to the World Health Organization (WHO, 2002) over 300 000 people died in 2000 as a direct result of violent conflicts. The rates ranged from less than 1 per 100 000 population in high-income countries to 6.2 per 100 000 in low- and middle-income countries. Torture, rape and violation of human rights are also used to terrorise and undermine communities. Violence not only results in death and direct physical injury but also affects mental health and subsequent physical health (WHO, 2002). According to the WHO, an estimated 1.6 million people worldwide lost their lives to violence in 2000. About half of the deaths were attributed to suicide, nearly a third were due to homicide, and about a fifth were casualties of armed conflicts.

Destitute states whose governments have collapsed provide fertile ground for the planning and preparation of appalling acts of violence. Such events, although differing in form over the years, have a long history, perhaps dating back to the very first human societies. They undoubtedly played a role in the creation of some of the global empires of past millennia. However, the spectacular nature of recent events, with large numbers of casualties, combined with the fact that they are now vividly reported worldwide, often within minutes, has made the world community feel very vulnerable. It is clear that no one and no place is truly secure while violence is endemic in various parts of the world.

There are of course many other types of violent behaviour, within and between families, in local neighbourhoods, streets and communities. Self-inflicted injuries, suicide, homicide and other acts of violence, including those against groups perceived as particularly defenceless, such as children and the elderly, frequently occur. Although they may not be widely reported, they contribute to and accentuate feelings of insecurity and lead to fearfulness. Because these events occur so frequently they have been 'normalised', so that they are often seen as an inevitable part of the human condition and therefore not susceptible to prevention. Indeed, in general, they are often considered as 'law and order' issues.

Various explanations have been put forward for the dynamics for different types of violence, including self-directed violence, which is considered to be the fourth leading cause of death and the sixth leading cause of ill health and disability (Platt, 1984; Murphy & Wetzel, 1990; Cavanagh *et al.*, 1999; WHO, 2002). There is also information on the factors that put states at risk of violent conflict (Carnegie Commission, 1997).

Whatever the causes, it is obvious that in addition to human misery, violence puts a significant burden on national economies in general and on health services in particular. In this context, it is important that the role of health professionals in dealing with the consequences of violence should be explored and accorded public health priority (Krug *et al.*, 2002).

The practice of medicine has always been important during conflicts and wars and also in response to other acts of violence. The most immediate and obvious response is the provision of physical care to those who have been physically injured, but it is generally acknowledged that the associated psychological pain, anxiety and stress also demand a response. Such reactions may affect those directly involved in the act of violence, those who witness it and those who were part of the immediate, interventional response, for example those from the emergency services who attended the scene and healthcare professionals receiving casualties. Collectively, there may be so many people involved that the community as a whole suffers from the psychological impact of the event.

Although this is familiar territory to psychiatrists, the psychosocial impact on individuals, families and communities is an area that has generally been neglected, apart from during the immediate aftermath of a violent act. Then, as the event fades away from media attention it is all too easy for it to fade also from the attention of policy makers and professionals. This is an immediate issue for the Royal College of Psychiatrists and other psychiatric associations to consider when planning responses to local violence. For example, psychiatrists can contribute to preparatory training for professionals who will take on the responsibility of assessing and meeting the needs of those who have suffered directly or indirectly as a result of an act of violence. Individuals requiring support may include: those most directly involved; those who have lost a relative, a friend or a colleague; those suffering from post-traumatic stress disorders; and the family and friends of the violent individuals themselves.

In addition, attention needs to be paid to wider issues. The media play an important role, not only in reporting events but also in influencing responses to them. Judicious use of the media can therefore be vital (Njenga *et al.*, 2003) in the aftermath of violent acts, and it may be appropriate for psychiatrists to offer advice and support to policy makers so that the public's natural feelings of insecurity are not increased by the hasty announcement of inappropriate actions.

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In this context, psychiatrists may also be able to contribute to scientific research on understanding the reasons behind violence against society, including gaining an understanding of the underlying ideological motivations. This is clearly of increasing importance if we are to prevent the development of a 'sick' society – one that is imbued with bitterness, resentment, revenge, aggression and violence. Political solutions alone, however sound, will never be fully effective unless attention is paid to helping individuals within society with their own emotional responses.

Tackling this problem energetically is important. 'Sick' societies provide an environment in which organised crime can develop and flourish. Drug-related crime and the illegal arms trade, for example, are particularly well known for the way in which they can undermine the authority of the state and provide funding for politically related violence. The Royal College of Psychiatrists and similar organisations may feel that it is not appropriate to become embroiled in the social and political factors that are often cited as the cause of violence, but such detachment should not interfere with unambiguous advocacy for human rights in all circumstances. Specifically, whatever the threat of violence,

psychiatry and psychiatrists should remain focused on the needs of those who are mentally ill and should resist political pressure to treat as sick those individuals whose behaviour may be inconvenient to those in power. The Royal College of Psychiatrists can make a very positive contribution to those ideas by maintaining robust links with psychiatrists in other countries and by supporting them in difficult situations.

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### THEMATIC PAPERS – INTRODUCTION

## Dementia in low- and middle-income countries

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Dementia care places considerable financial burdens on families.... The idea that extended family care reduces this problem is misleading, and certainly does not apply to those families for whom survival depends on all family members working.

It is 100 years since Dr Alois Alzheimer, a German neurologist, observed changes in the brain that are now known to be the characteristic features of Alzheimer's disease, the commonest form of dementia. Until recently this condition was thought to occur only infrequently in low- and middle-income countries; now it has been realised that the prevalence is as high in these countries as in the rest of the world. Further, because of the rapidly increasing numbers of older people in low- and middle-income countries, they contain far more people with dementia: 16 million compared with 8 million in high-income nations. How can ways be found to provide adequate care for people with dementia in these countries when resources, both skilled manpower and finance, are so limited? The thematic papers that follow address this issue.

In their article 'Ageing and dementia in low- and middle-income countries', Martin Prince and Daisy Acosta point first to the degree to which the burden of disability in these countries, as elsewhere, falls disproportionately on older people, who are likely to suffer from multiple disorders. They describe the 10/66 Dementia Research Group, a remarkable collaborative

venture that aims to develop standardised diagnostic procedures, undertake comparative prevalence studies and describe care arrangements and patterns of service development in low- and middle-income countries. The links between this group and Alzheimer's Disease International (itself the subject of an article in this issue under 'Associations and collaborations') provide a bridge with the voluntary sector that allows research findings to be rapidly disseminated and utilised to the benefit of the affected populations.

Dementia care places considerable financial burdens on families. Carers are often prevented from working because of the need to provide full-time care for their affected relative. The idea that extended family care reduces this problem is misleading and certainly does not apply to those families for whom survival depends on all family members working.

In the paper on dementia care in Latin America, Aquiles Salas and Raul Arizaga describe the situation in Venezuela, where few people receive adequate non-contributory benefits; most people over the age of 65 receive only US\$35 a month. The problem is compounded by the fact that virtually all medical and day care services are privately provided. Under the