Rethinking trauma as a global challenge

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Rethinking trauma

Outline

- Violence as a public health problem
- Traumatic injuries
- Global fatalities and fatal discontinuities
- Rethinking trauma
- Trauma and recovery: emerging controversies

- Conclusions
- The Trauma & Global Health Program

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- Violence as a cause has grown to such magnitude in recent years that has become a worldwide leading cause of death for people aged 15-44 years.

- In effect, “external causes” rank fourth in worldwide causes of death, after cardiovascular diseases, infectious diseases, and cancer (WHO, 2002).

  - 1/3 intentional violence (suicides, homicides, and organised violence: terrorism, wars and armed conflict, genocide and ethnic cleansing) are more difficult to prevent and control

  - 2/3 non intentional violence (e.g., traffic accidents) are relatively easier to prevent and control

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Estimated global violence-related deaths, 2000

Type of violence	Number	Rate per 100,000 population	Proportion of total (%)
Homicide Suicide War-related	520 000 815 000 310 000	8.8 14.5 5.2	31.3 49.1 18.6
Total	1 659 000	28.8	100.0
Low to middle-income countries	1 510 000	32.1	91.1
High-income countries	149 000	14.4	8.9

Source: WHO Global Burden of Disease project for 2000, version 1

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Estimated global homicide and suicide rates (per 100,000) by age group and sex, 2000.

Age group (years)	Homicide rate		Suicide rate	
	Males	Females	Males	Females
0-4	5.8	4.8	0.0	0.0
5-14	2.1	2.0	1.7	2.0
15-29	19.4	4.4	15.6	12.2
30-44	18.7	4.3	21.5	12.4
45-59	14.8	4.5	28.4	12.6
60+	13.0	4.5	44.9	22.1
Total (age standardized)	13.6	4.0	18.9	10.6

Source: WHO Burden of Disease project for 2000, Version 1

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- **Neuropsychiatric disorders = 31.7% of DALYs**
  - **Unipolar depression : 11.8%**
  - **Alcohol-use disorder: 3.3%**
  - **Schizophrenia: 2.8%**
  - **Bipolar depression: 2.4%**
- **Violence and self-inflicted injuries = 6.7% of TBD among males 15-44**
- **More than 20 million people with trauma-related sequelae and disabilities caused by violence and diverse external causes which are increasing significantly in LMICs.**
- **Self-inflicted injuries are the 5th leading cause of mortality in LMICs**
- **Suicides (underreported) and self-inflicted injuries account for a quarter to a half of all deaths among young women (e.g. China and India).**

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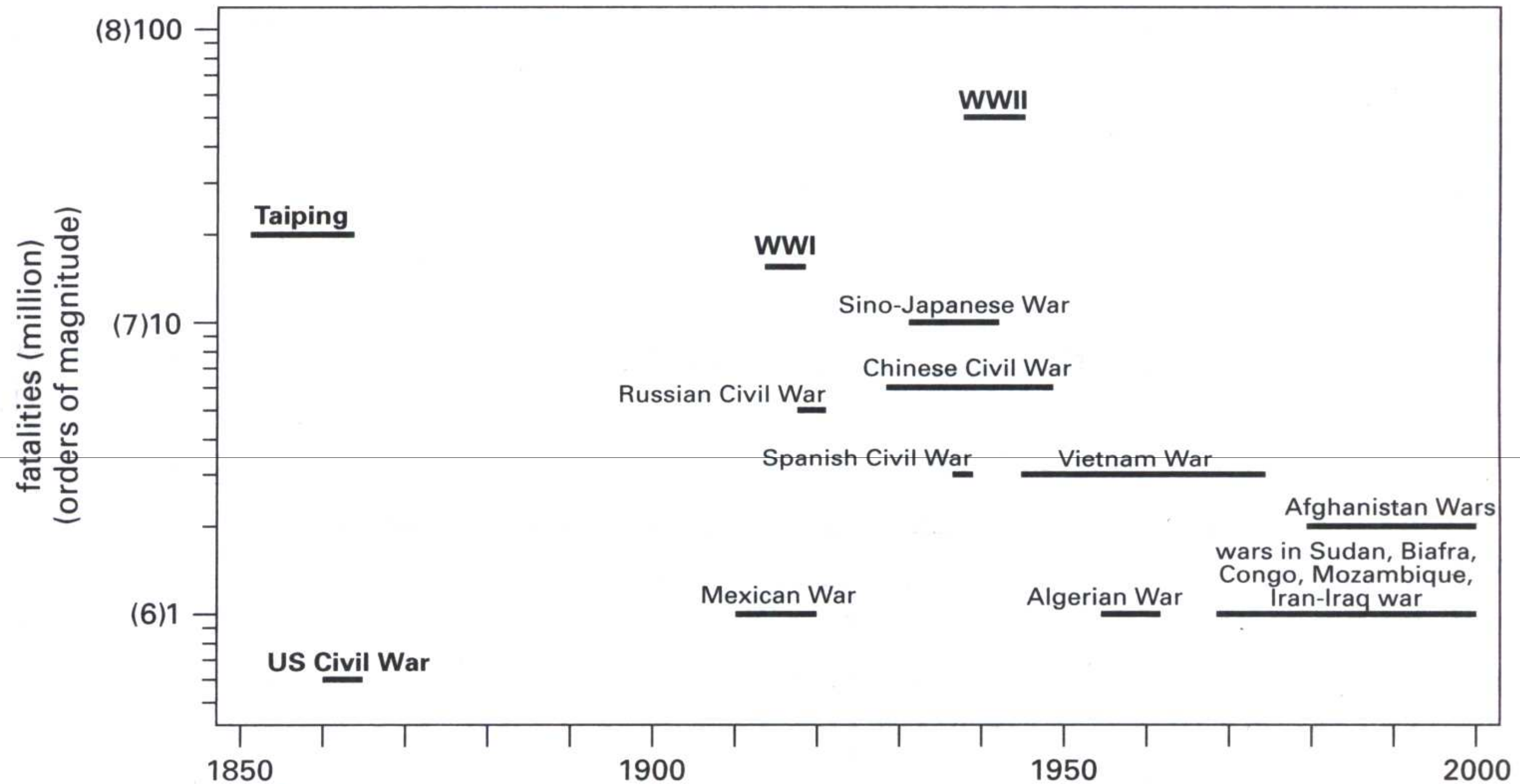

Fig. 2.19
Wars of magnitude 6 or 7, 1850–2000. Boldface font indicates wars that the author considers transformational. Plotted fatalities are minimal to average (heavily rounded) estimates from sources cited in the text.

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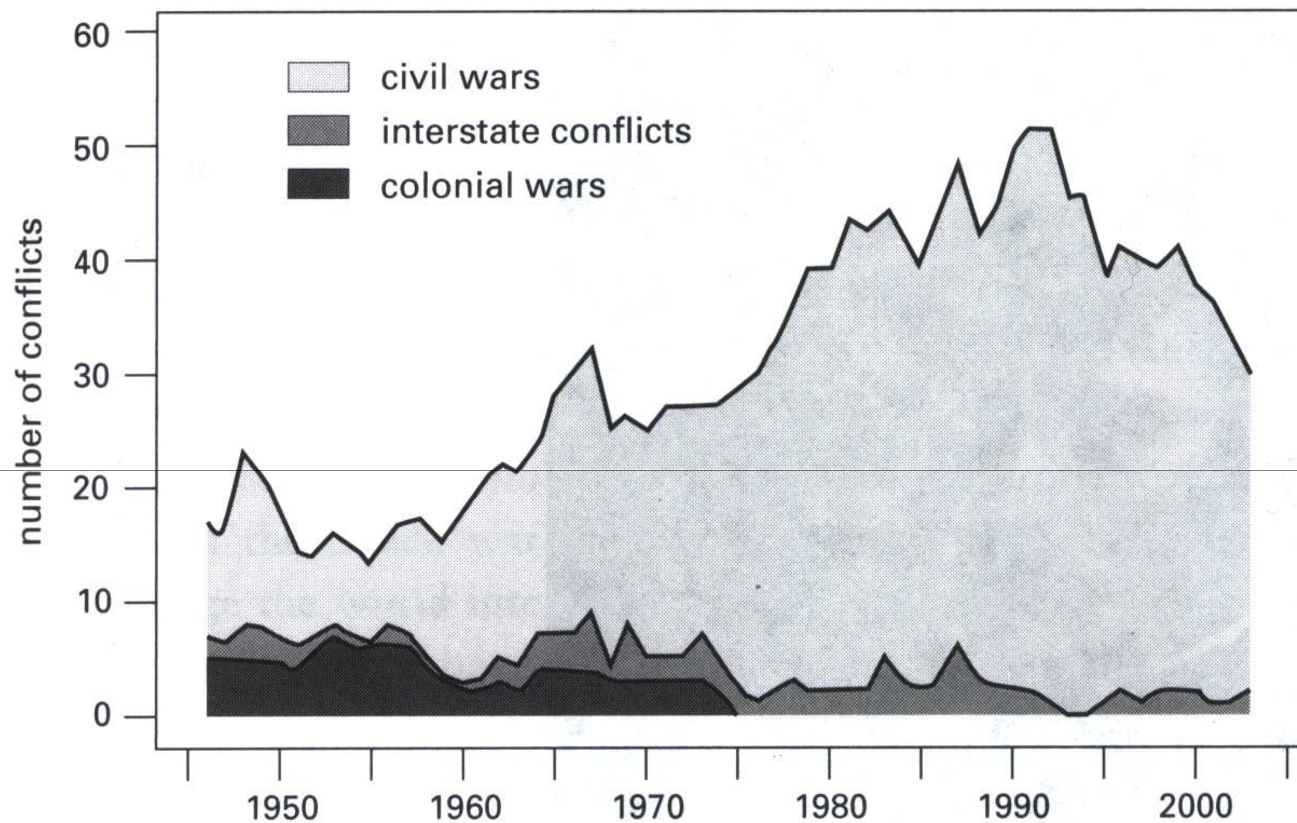

Fig. 2.20
Worldwide conflicts, 1946–2003. From Human Security Centre (2006).

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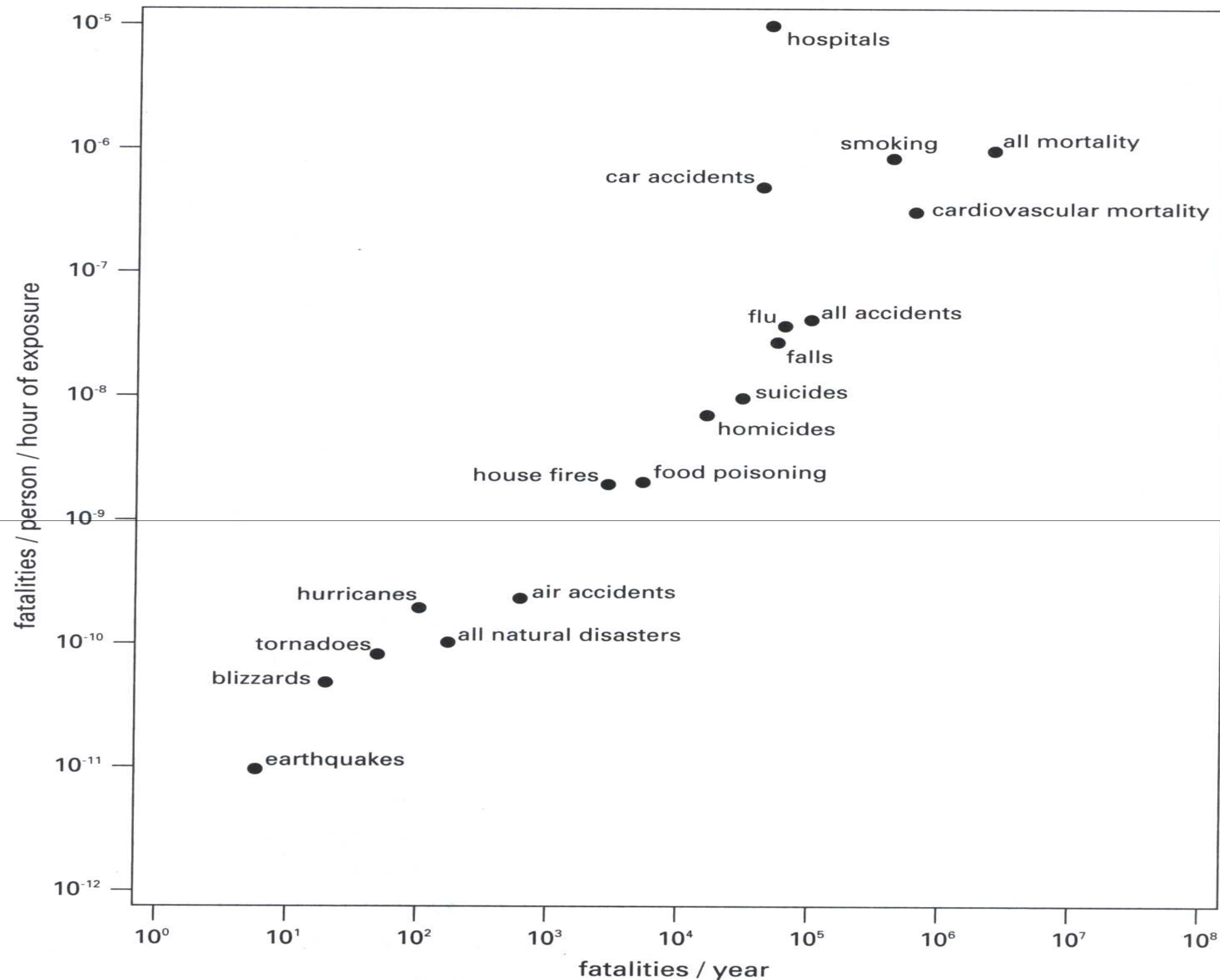

Fig. 5.3
U.S. fatalities per person per hour of exposure vs. average annual number of fatalities, 1991–2005. Both axes are logarithmic. Calculated from data published by Centers for Disease Control and Prevention, National Transportation Safety Board, National Weather Service, and U.S. Geological Survey.

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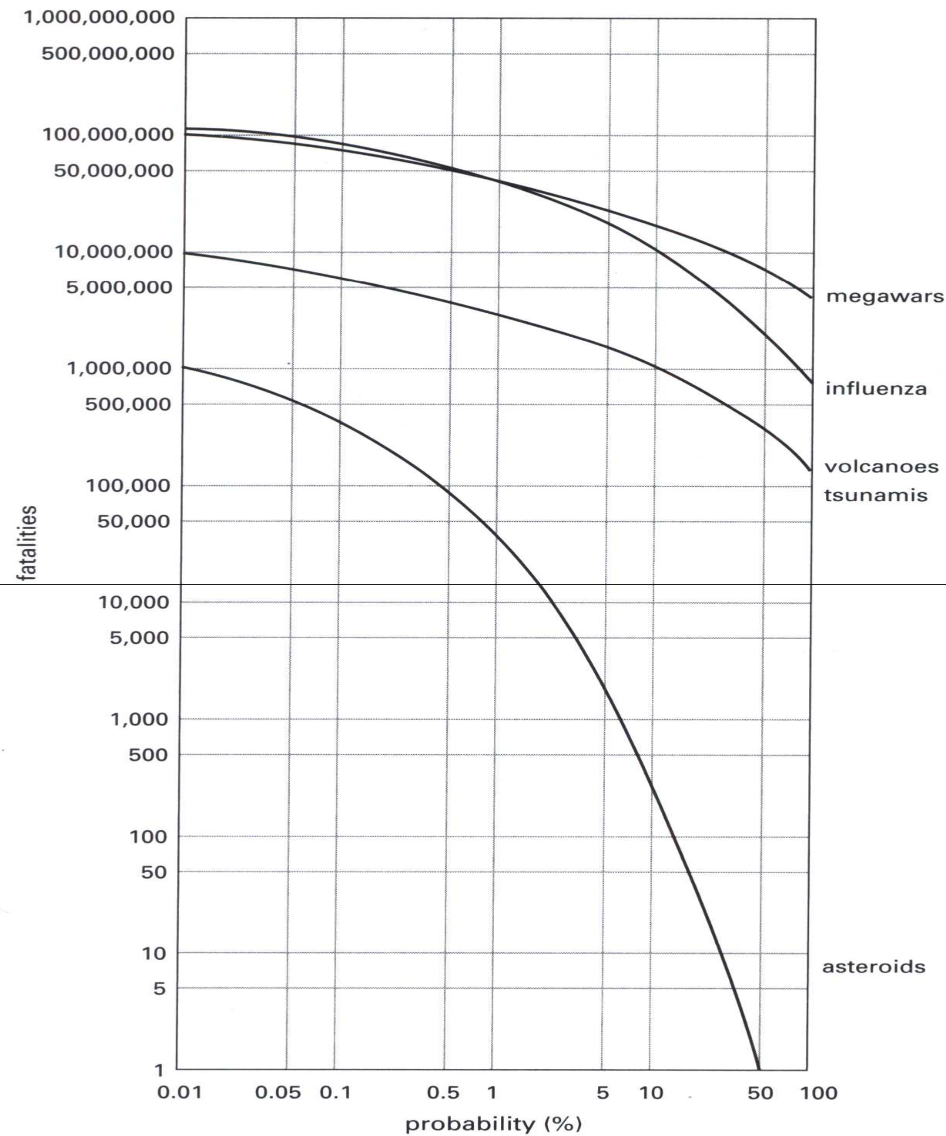

Fig. 5.6
Probabilities of fatal discontinuities during the first half of the twenty-first century, from an extremely low chance of catastrophic asteroid impacts to near-certainty of another virulent influenza epidemic. All curves are approximate but show correct orders of magnitude. Calculated from data presented in chapter 2.

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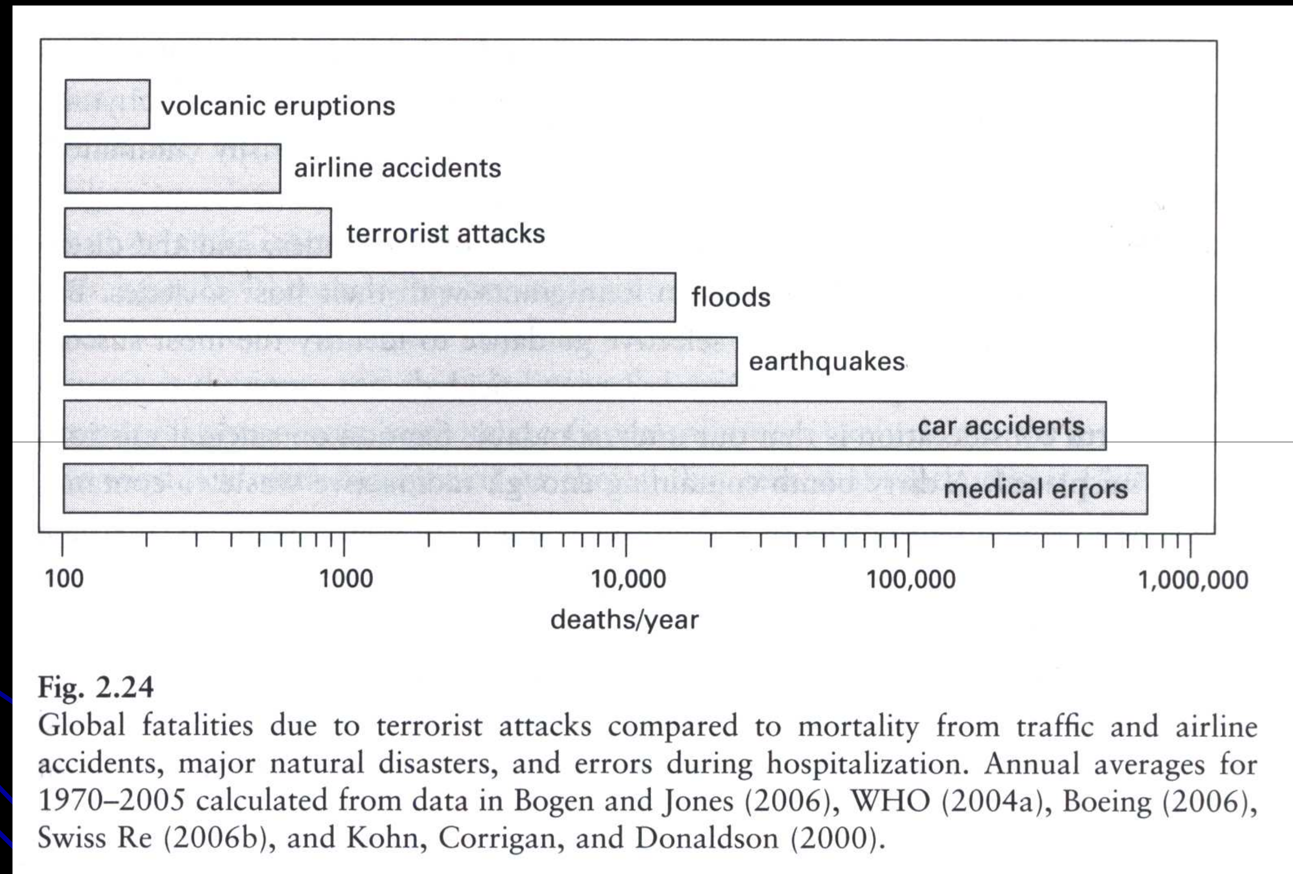

Fig. 2.24
Global fatalities due to terrorist attacks compared to mortality from traffic and airline accidents, major natural disasters, and errors during hospitalization. Annual averages for 1970–2005 calculated from data in Bogen and Jones (2006), WHO (2004a), Boeing (2006), Swiss Re (2006b), and Kohn, Corrigan, and Donaldson (2000).

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- **Traumatic injuries: 4.2 million annual deaths and more than 20 million people with trauma-related sequelae and disabilities caused by violence and diverse external causes → are increasing exponentially.**
- **Trauma: asymmetric geographical distribution (regional variations)**
- **Trauma: asymmetric social distribution**
  - **Poverty**
  - **Urbanization**
  - **Illiteracy**
  - **Rapid population growth**
  - **Forced migration and displacement (refugees)**
  - **Gender**
  - **Social inequalities and social exclusion**

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- **Trauma: the hidden part of the iceberg - psychological trauma**
  - **Victims of violence (of intentional origins) are at increased risk of a wide range of psychological and behaviour-related problems: PTSD, depression, alcohol abuse, anxiety, suicidal behaviour, STDs, HIV/AIDS, etc.**
  - **Natural catastrophes and complex emergencies also have poor mental health outcomes.**
- **Traumatic events have far broader, more varied and complex meanings and effects than those recognized by conventional medical nosology and psychiatric practice.**
- **These effects evoke a wide range of culturally specific healing, coping and adaptive strategies that are poorly understood.**

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- Psychological trauma is today an ubiquitous, emblematic category in continuous transformation, more and more inclusive…

- PTSD is not a single disorder, but a family of disorders...

- The metamorphosis of the trauma construct (PTSD) makes it difficult to assess and problematic to follow its natural history

  - from a rare event (stressor) which always have poor health outcomes or induces severe distress in the majority of the exposed… to a relatively common event/s that induces serious distress in a minority of individuals
  - from being a cause… to being an outcome
  - changes in the locus of trauma

- After 9/11 trauma adopts a new identity as a phenomena of epidemic proportions, from which new forms of trauma seem to evolve: virtual PTSD, distanced trauma, tertiary trauma, etc.

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Trauma and recovery: emerging controversies

- Consensus: the direct consequences of exposure to traumatic experiences → increased disability, morbidity and mortality, including the presence of trauma and PTSD symptoms found in diverse cultural contexts

- Emerging controversies and lack of consensus:
  - Is there a relation of causality between exposure to a traumatic event and psychological trauma?
  - Are PTSD symptoms a "normal" or a "pathological" occurrence after exposure to traumatic events?
  - Which are the residual (long-term) effects attributable to sustained exposure to violence?
  - How trauma effects tend to fade away with the passing of time?
  - Why some people exposed to violence develop PTSD symptoms while others remain apparently healthy?

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- Current responses to massive traumatic experiences:
  - Relief → Stabilization → Rehabilitation → Peace Building → Post-conflict reconstruction →Development assistance
  - Medical model (psychopathology vs. resilience) (individual vs. collective)
  - Lack of evidence or inadequate evidence on effectiveness of existing therapies for PTSD: 2771 studies→ 37 RCTs on pharmacotherapy and 52 on psychotherapy (IOM, 2008)

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- **Clinical ambiguity or uncertainty:**
  - **is complete remission an attainable goal?**
  - **who should (or should not) receive medication?**
  - **how and why it work in some cases and not in others?**

- **Lack of evaluation of collective interventions**
  - **before and after**
  - **health outcomes**
  - **overall quality of life and well being**

- **Dilemma of horizontal vs. vertical (focused) interventions**
  - **mental health remains a low priority**
  - **untreated mental disorders are high**
  - **neutral or harmful interventions in management of traumatic stress**
  - **monovalent vs. multivalent (multisectorial) interventions**

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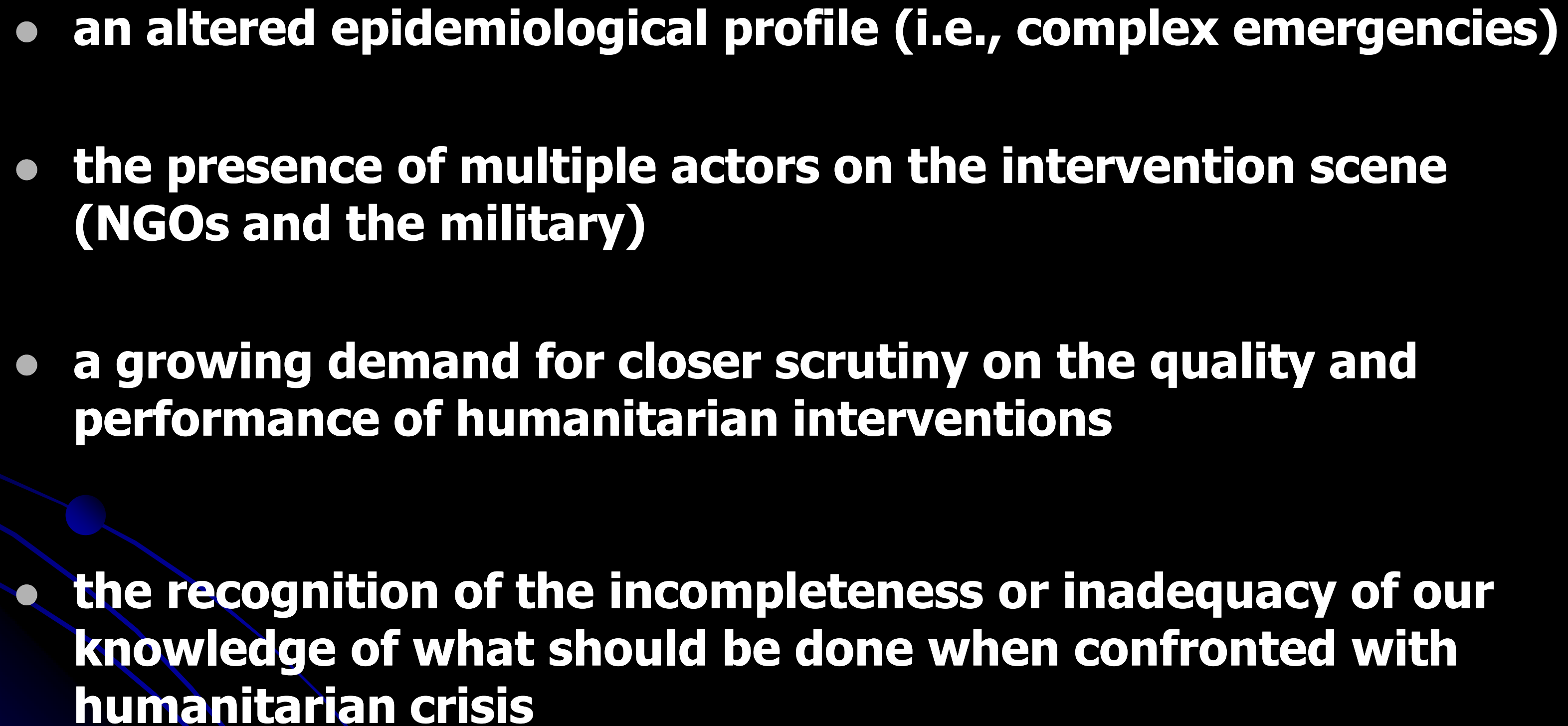

The new context of humanitarian interventions:

- **an altered epidemiological profile (i.e., complex emergencies)**
- **the presence of multiple actors on the intervention scene (NGOs and the military)**
- **a growing demand for closer scrutiny on the quality and performance of humanitarian interventions**
- **the recognition of the incompleteness or inadequacy of our knowledge of what should be done when confronted with humanitarian crisis**

Conclusions:

- **The interrelations between violence, trauma and collective health are non-linear and more complex than we expected.**
- **Psychological trauma is today an ubiquitous, emblematic category in continuous transformation, more and more inclusive and invasive of our daily life.**
- **After 9/11, PTSD adopts a new identity as a phenomena of epidemic proportions, from which new forms of PTSD seem to evolve: virtual PTSD, distanced trauma, tertiary trauma, etc.**

Conclusions (cont.)

- **The social, political and cultural realities structure the context in which violence and trauma are collectively experienced and determine to a greater or lesser degree:**
  - **a) the subjective meaning of violence and traumatic events;**
  - **b) the way in which distress is experienced and reported;**
  - **c) what type of responses (incl. therapy) are available and which ones are considered most effective and appropriate.**
  - **d) the type and extent of social support available and its protecting effects**

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<u>Conclusions</u> (cont.)

- The contexts where humanitarian interventions are being applied have differing norms, values and traditions, a range of attributions and understandings of causality, different ways of expressing emotions, distress and suffering, and different approaches to help-seeking, healing and coping with traumatic events and adversity.

- We should be cautious of looking at the consequences of violence and responses to war and natural disasters through a Western lens… *trauma* is not the only outcome and *recovery* may not be the result of a simple enterprise.

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Conclusions (cont.)

- The lessons of history are straightforward. Recovery is not a discrete process: it happens *in people's lives* rather than in the intra-psyche or in their psychologies.

- Recovery is *practical* and *unspectacular*, and it's grounded in the resumption of the ordinary rhythms of everyday life – the familial, community, religious, cultural and economic actions that make the world intelligible (Summerfield 2002; Pedersen 2008).

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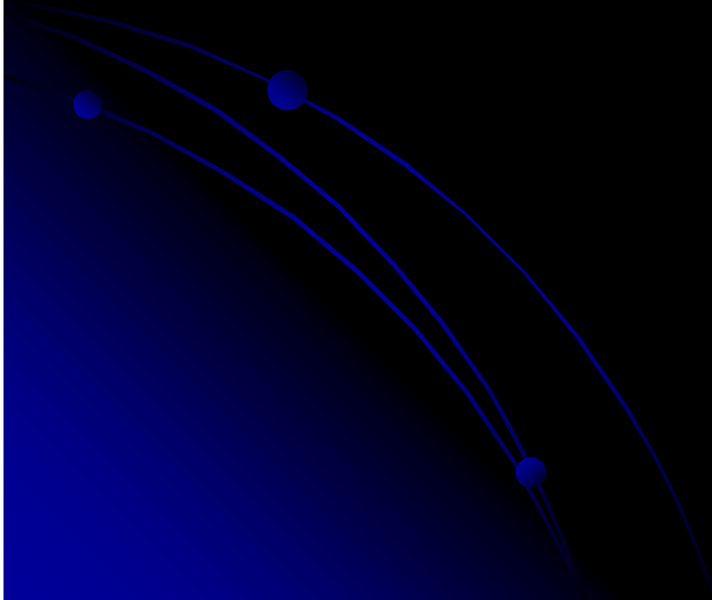
- www.mcgill.ca/trauma-globalhealth



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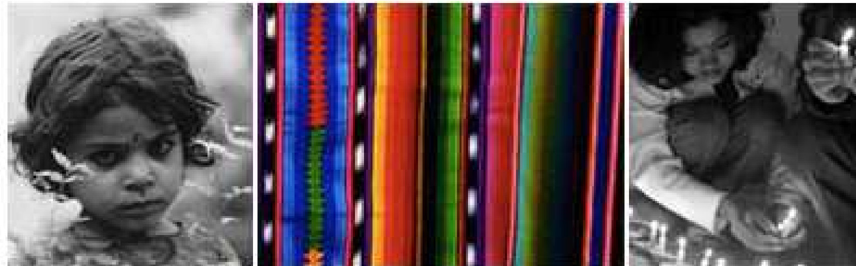
News

Feature Interview on IDRC Website

January 2009 | Click here for interview with Trauma and Global Health Program team members Duncan Pedersen, Victor Lopez, and Marina Piazza posted on the International Development Research Centre website.



Trauma and Global Health Program

Political violence, natural disasters and mental health outcomes: developing innovative health policies and interventions

The **Trauma and Global Health Program** stems from a partnership between the Douglas Institute - McGill University and research teams based in Guatemala City (Guatemala), Khatmandu (Nepal), Lima (Peru), and Colombo (Sri Lanka). Two additional teams, based in Gaza (Palestine), and Bujunbura (Burundi), have also expressed their interest to become members of this global health research initiative. Our TGH program is funded by the Global Health Research Initiative - Teasdale-Corti Team Grants Program and supported by the Douglas Mental Health University Institute and McGill University.

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- The Trauma and Global Health program aims to build a sustainable research environment in partnership between the Douglas Institute-McGill University based in Montreal, *Canada*, with research teams and their host institutions from low and middle-income countries: *Guatemala, Nepal, Peru*, and *Sri Lanka*, including the *occupied Palestinian Territories*, and to conduct a global research and action program of advanced studies, continuing education, capacity building and knowledge translation in the social and cultural dimensions of mental health, focussed on the development and assessment of culturally appropriate interventions for the prevention and treatment of trauma-related disorders.

- The ultimate objective of the program is to reduce the mental health burden of civilian populations exposed to *protracted* violence and episodic natural disasters, foster the process of healing, psychosocial rehabilitation and recovery, and generate improved mental health policies and services in the participating countries.

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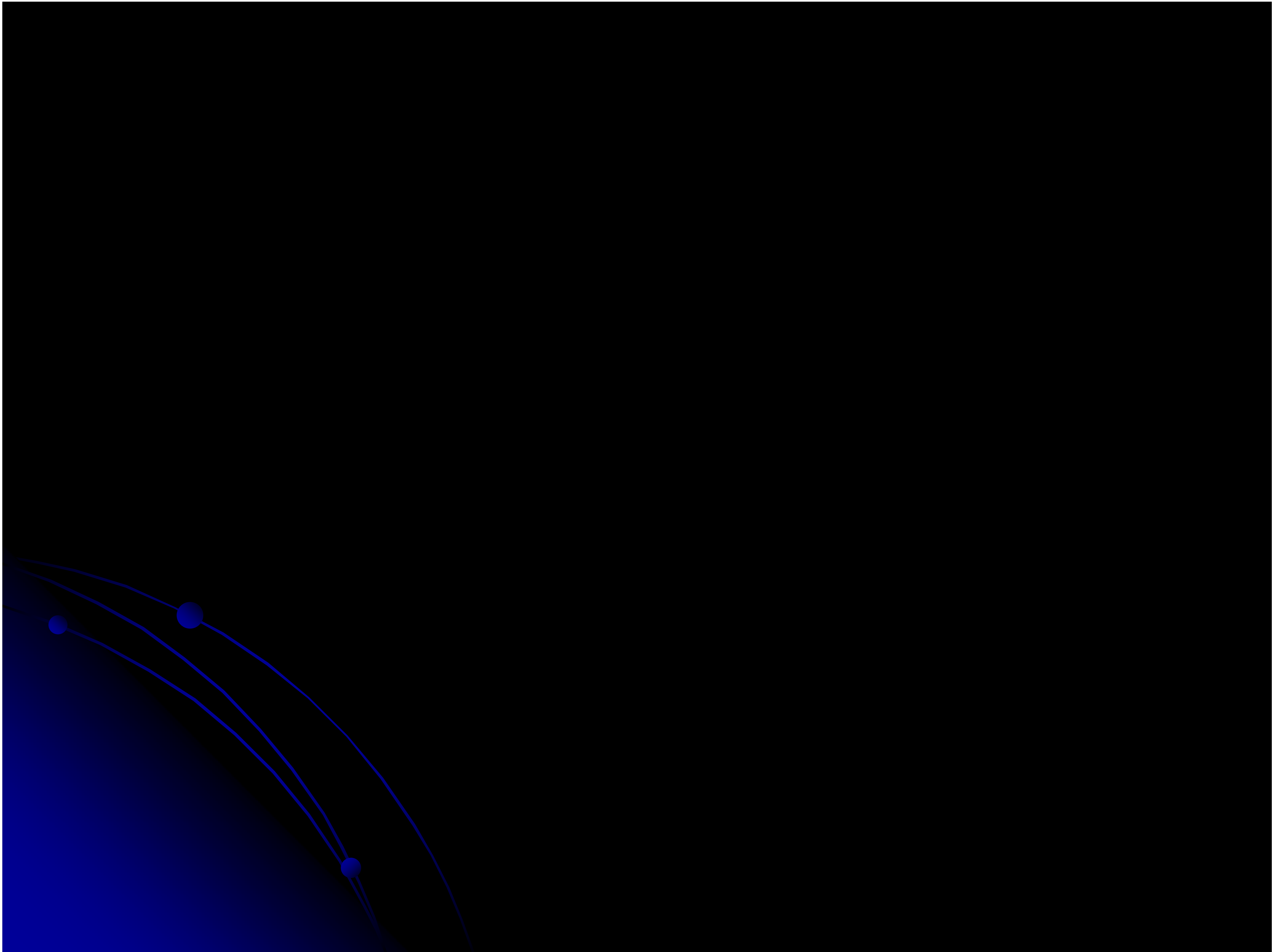

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- Five questions to think about trauma in a global context

- Is there a relation of causality between exposure to a traumatic event and psychological trauma?
- Are PTSD symptoms a “normal” or a “pathological” occurrence after exposure to traumatic events?
- Why some people exposed to violence develop PTSD symptoms while others remain apparently healthy?
- How effective are the existing therapies for trauma-related disorders?
- What are the existing paradigms for helping individuals, families and communities manage and cope with adversity?