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Preventive Psychiatry Implementation in the Management of Traumatized Palestinians

Präventive Psychiatrie im Management traumatisierter Palästinenser

Zusammenfassung Psychiatrische Prävention bzgl. Traumatisierung im Gazastreifen kann sich auf die Reduktion des traumatisierenden Ereignisses, die Dauer der Symptomatik und der Ernsthaftigkeit/Schweregrad des persönlichen Leidens beziehen. Das Krisengebiet und der tägliche Terror führen zu Chronifizierung und Retraumatisierung. In der jüngsten Zeit erleben mehr Menschen als zuvor direkte Gewalt. Hinzu kommen die sozialen Konsequenzen wie Armut, Arbeitslosigkeit.

Es wird die Traumatisierung des einzelnen Menschen unterschieden von der der traumatisierten Nation. Vor allem Kinder sind ständig traumatisierenden Erfahrungen ausgeliefert. Die Reaktion von Kindern hierauf ist eingehend untersucht worden, ebenso die weitreichenden tragischen psychologischen und sozialen Auswirkungen.

Es werden unterschiedliche Wege aufgezeigt präventiv im sozialen Bereich und im persönlichen/familiären Bereich zu unterstützen/präventiv tätig zu werden. In diesem Zusammenhang wird die Frage diskutiert, ob Psychiater/Psychotherapeuten/Sozialarbeiter in der sozialen und medialen Öffentlichkeit sich auf die Wechselwirkung von Traumatisierung, sozialem Leben, politischem Druck und Gewaltanwendung äußern dürfen. Eine wichtige Aufgabe wird darin gesehen, die Stigmatisierung und das Bewusstsein von Stigmatisierung zu verringern.

Schlüsselwörter:
Prävention; Traumatisierung; Symptome von Kindern; spezifische Interventionen; Stigmatisierung; Traumacounseling; politisches Handeln als Psychotherapeut.

Introduction

Many of the early advances in medicine, contributing to the increases in life expectancy that occurred in the 19th century, were due to developments in prevention. These particularly involved the infectious diseases, *with identification of the causes and prevention of some of them*, such as control of the sources of infection for cholera, enhancement of host immunity in vaccination for smallpox; and general improvements in host resistance as nutrition improved.

More recently the importance of prevention has again been recognized. Epidemiological studies have pointed to major contributing factors to cancer, chest disease and heart disease, such as smoking, diet and lack of exercise. Considerable investment has been made in public health programmes to modify these. *Screening programmes have been set up to detect disorder while it is early and treatable, such as those for cervical and breast cancer.*

In many aspects psychiatric disorders are considered major public health problems.

But despite the fact that psychiatric disorder causes considerable personal disability and distress in families, psychiatry has tended to be slower in preventive developments and the approaches have been more tentative.

Primary prevention

Primary prevention efforts are those directed at reducing the incidence (rate of occurrence of new cases) in the community. Primary prevention efforts are directed at people who are essentially normal, but believed to be "at risk" from the development of a particular disorder.

These can respond to improvements in psychiatric services for care of the primary disorders. Beyond these specifics, social causative factors have implications for primary prevention.

Similarly it is easier to tackle precipitating factors where the link with onset of disorder is closer, rather than predisposing factors. Coping responses are more amenable to intervention than is removal of social stresses themselves, many of which are bound up with the inevitable consequences of the life-cycle. What is not at present feasible in primary prevention is to change dramatically cultures or societal structures.

Secondary prevention

Involves efforts to reduce the prevalence of a disorder by reducing its duration. Thus secondary prevention programmes are directed at people who show early signs of disorder, and the goal is to shorten the duration of the disorder by early and prompt treatment

The situation is similar but the opportunities greater in secondary prevention. The use of screening techniques is highly feasible with many of the common disorders in psychiatry, particularly depression, anxiety and other common symptoms seen after exposure to trauma e.g. nightmares, irritability, avoidance. When combined with interviewing to establish presence of disorders which exceed thresholds for clinical criteria, it is straightforward and

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merits wider adoption. When it involves detection of subthreshold disorders, it requires evaluation in controlled designs, to determine whether detection and intervention in early disorders is justified in terms of benefit and cost.

Tertiary prevention

Is designed to reduce the severity and disability associated with a particular disorder.

Here the situation is different; as it is already well established in psychiatry. It involves not only prevention of disability but also prevention of recurrence. The value of prophylactic maintenance drug treatment is well proven in affective disorders and schizophrenia, and there is good evidence for the effects of family intervention in high expressed emotion schizophrenic families. The place of behavioral and cognitive approaches in anxiety and PTSD is growing. Service-related local case registers can be useful for identifying and monitoring vulnerable groups.

Difficulties

Attempts to apply prevention in psychiatry have encountered a number of difficulties. For *primary prevention* a prerequisite is an adequate base of knowledge of causes. In respect of psychiatric disorders this is only partly available, but there is now a substantial body of knowledge, particularly concerning social aspects.

A key issue is that most psychiatric causation is multi-factorial. Single causes, such as adverse early home environments or recent life stresses may contribute to many disorders. A single disorder commonly appears to have many contributing causes. For instance, causes of depression range from genes and effects of some amine-depleting drugs, to psychosocial factors such as bereavement, interpersonal losses, and threats to self-esteem.

From the point of view of *secondary prevention*, the boundaries between predisorder and disorder are vague, since both can only be detected by the presence of certain symptoms, and the same symptoms, at a more severe level, define disorder. This is really a semantic issue and it applies also in other areas where screening has been used. A more substantive question is whether detecting and treating early disorder will prevent the development of major disorders and of prolonged disorders, and is a cost-effective method of doing so. It might be the case that early and mild disorders most often have a good spontaneous outcome. These are questions for empirical testing. The evidence available suggests that milder and neurotic disorders do not generally proceed to psychoses but are often prolonged, thus secondary prevention can be helpful.

From the standpoint of *tertiary prevention*, the major question is whether this is to be regarded as prevention rather than treatment. However, much psychiatric disorder developing after trauma are recurrent and have chronic coarse; effective measures to eliminate recurrence can have major effects in reducing prevalence and do not necessarily involve treatment of, or presence of, any active symptoms.

Application of concepts in dealing with trauma

The human chaos of disasters is not random. Rather traumas and disasters are structured by the complex feelings, thoughts and behaviors which are part of every disaster and trauma. For most individuals these feelings, thoughts and behaviors are transitory. For some, they linger long after the traumatic event has passed, recalled in memory by new experiences which serve as a reminder of the past trauma.

Traumas and disasters affect thousands of Palestinians: victims, their relatives, their friends, disaster workers, and witnesses. Recently, there has been a significant increase in number of people affected directly by violence. During this war like situation, which is still ongoing, people have been traumatized in many ways. Traumatic experiences range from being injured to witnessing killings and injuries of relatives and friends or loosing family members or close friends. Many were victims of home demolitions and destructions of farms including uprooting of trees. The ongoing closure of the Gaza Strip prevents thousands of fathers from reaching their working places and deprives their families of their income. The unemployment rate and the poverty are increasing daily. Internal closures between the north and the south of Gaza prevent people even to move within the Gaza Strip. This has also a serious effect on the functioning of the schools, because many teachers as well as students can not reach their schools. Shooting from helicopters, Jet fighters and tanks traumatizes thousands of people and leaves them with anxiety.

The number of Palestinians killed at the hands of the Israeli Army and settlers is more than 2000, while the number of people injured is well above 30,000. When examined across different regions, people living in areas nearby settlements and near police stations are at higher rates of exposure to traumatic incidences.

The psychological responses of individuals to trauma vary greatly. The meaning of any traumatic event is a complex interaction of the event itself and the individual's past, present, and expected future as well as biological givens and social context (Ursano, Fullerton, 1992). The meaning of the trauma affects not only how the trauma is experienced initially, but also the way in which recovery occurs and life is reestablished. Overall, most individuals exposed to traumatic events and disasters do quite well and do not suffer prolonged psychiatric illnesses. But for some, psychiatric illness, behavioral change, or alterations in physical health result. Certainly, no one goes through profound life events unchanged.

The ability of communities to plan for, and recover from, a disaster must be the focus of a community's leadership and rescue services. If disaster plans do not consider the psychological effects of trauma, the consequences can overwhelm all available services and resources, exhausting rescue workers as well as victims

Defining traumatic events and disasters

A traumatic event is recognized by the nature of the events, by the effects of the trauma on individuals and groups, and by the responses of individuals and groups to the event. In general, traumatic events are dangerous, overwhelming, and sudden (Figky, 1985). They are marked by their extreme or sudden force, typically causing fear, anxiety,

withdrawal, and avoidance. Traumatic events have high intensity, are unexpected, infrequent, and vary in duration from acute to chronic.

The traumatized nation in Gaza Strip-outlook

The Gaza Strip is described as an area of extreme, impenetrable complexity-geographic, demographic, economic, social, political, and legal. Geographically, it lies wedged between two larger, more powerful countries, Egypt and Israel both of which rolled over it in turn. Gaza strip is an area of highly traumatic experiences. For the last 54 years it has passed through many wars and political and economic instability. The experience of violence is pervasive among Palestinian living in the Gaza Strip.

The prevalence of direct and witnessed exposure rates amongst Palestinian children to tear gassing, physical injury and house searches, to name a few, by Israeli soldiers has been well documented in numerous reports (see Nixon, 1990; Graff, 1991; Abu Hem et al., 1993). Documentation of the health impact on these children as a result of that trauma exposure, particularly during the beginning of the Intifada had, until recently, been confined to its effect on their physical health. Less was understood about the emotional or psychological impact of living under conditions of military occupation and resistance to that occupation.

Palestinians in Gaza Strip are suffering from the harsh life conditions of the Gaza Strip, but more so during Alaqsa Intifada as they were shot, arrested, and exposed to tear gases, they had their homes shelled and demolished, their friends and relatives injured and even killed. During the last 2 years almost 2000 Palestinians were killed and 10's of thousands were injured with 2500 were left with permanent disability. As a response Palestinians were themselves involved in violent attacks against the Israeli Army and civilians leading to 570 deaths and almost 5000 injuries. The Israeli Army in turn responded with more aggression generating more and more anger and frustration.

People on both sides were trapped in the vicious cycle of violence which still cultivates innocents on both sides (Fig. 1).

This violence has not only affected the social and political status of the Palestinian population but the psychological well being of a vast number of Palestinian people.

Information that was available on those psychological effects was collected mainly by mental health workers, psychologists and researchers who reported mostly descriptive accounts, case histories or narratives of children's reaction to trauma exposure (Graff, 1991; Garbarino, 1991).

Standardized tests investigating cognitive function have also been conducted with the attempt to correlate change in performance with living under occupation (Baker and Arafat, 1990; Qouta, Punamaki and El Sarraj, 1995).

More recently symptom-related behaviors have been observed. The general focus has been to determine rates of symptoms and behaviors of Palestinian children such as nightmares, fighting, bed wetting, fear and anxiety, to list a few. Attempts were made to relate these symptoms to various traumatic events or participation in the Intifada. For instance, Qouta, Punamaki and Sarraj (1993) studied the psychological effects of collective punishment and home demolition on children in Gaza and found a positive correlation between exposure and neurotic symptoms, fighting, and fears.

In a separate study, they investigated in 108 children the relation between traumatic experiences and cognitive and emotional responses among children in Gaza (Qouta et al., 1995). Among their findings they concluded that children exposed to a higher frequency of traumatic incidents showed increased psychological distress in the form of neurotic symptoms and greater risk taking.

In the past few years, researchers have begun to assess more formal diagnostic psychiatric outcomes like Post Traumatic Stress Disorder (PTSD). In adults, Khamis (1993) determined the rates of PTSD amongst a selected group of men who incurred serious physical injuries due to participation in the Intifada. She found a rate of PTSD of approximately 50% amongst the male population. Thabet and Vostanis (1999) have found that between 35–40% of children ages 6 to 11 in Gaza are suffering from moderate to severe levels of PTSD.

In the most recent research carried out by Gaza Community Mental Health Programme Research Department (Quota, 2001) in one highly affected area by shillings in the Southern Governate of Gaza Strip where 121 children aged 3-16 years of age were studied it was found that there was an increase in the rates of exposure to trauma, 99.2% of the group's homes were bombarded, 97.5% were exposed to tear gas, 2.5% suffered from burns, 1.7% were hit by rubber bullets, 2.5% were hit on the head and were rendered unconscious, and 2.5% were prevented from reaching medical care.

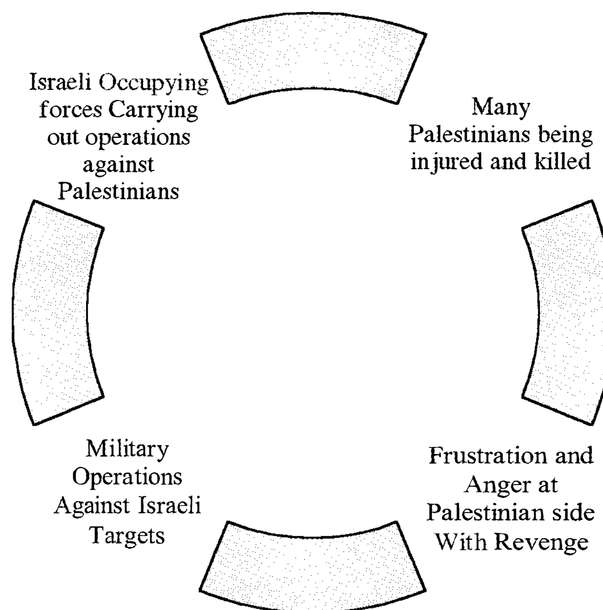

Fig. 1

Mise en place de services de psychiatrie préventive destinés à des Palestiniens traumatisés

Résumé La psychiatrie préventive en rapport avec les traumatismes subis par les habitants de la bande de Gaza s'intéresse à la réduction des événements traumatisants, de la durée des symptômes et de l'importance/de la sévérité de la souffrance individuelle. La crise et la terreur au quotidien font que les troubles deviennent chroniques et que les patients sont retraumatisés. La violence directe touche maintenant plus de personnes qu'avant. A ceci s'ajoutent des problèmes sociaux comme la pauvreté et le chômage.

Une distinction est effectuée entre le traumatisme subi par l'individu et celui qui est subi par la nation. Les enfants surtout sont constamment soumis à des vécus traumatisants. L'auteur a examiné en détail leurs réactions, ainsi que les effets tragiques des traumatismes au niveau psychologique et social.

Plusieurs approches sont mises en évidence, qui permettent de pratiquer la prévention et d'offrir un soutien dans le domaine social et personnel/familial. Dans ce contexte, l'auteur pose la question de savoir si le psychiatre, le psychothérapeute, le travailleur social devraient s'exprimer en public – dans les médias et dans la société – sur les interconnections entre traumatismes, vie sociale, pression politique et utilisation de la violence. Il considère comme important qu'ils contribuent à ce que les individus soient moins stigmatisés et stigmatisent moins autrui.

Also there was an increase in the rate of exposure to trauma as a result of witnessing it: 96.6% of the children witnessed shootings, 51.7% saw injured or dead who were not relatives, 35.1% saw their neighbors injured or killed, 22.9% saw family members injured or killed, and 95.8% witnessed bombardment and funerals. The increase in exposure to trauma led to an increase in the rate of PTSD symptoms:

- 54.6% of the children started to develop severe PTSD symptoms
- 34.5% of the children started to develop moderate PTSD symptoms
- 9.2% of the children started to develop mild PTSD symptoms

In addition to the increase in PTSD symptoms, it was discovered that 13.3% of children are suffering from a sharp increase in mental and behavioral problems such as sleep disorders, hyperactivity, speech disorders, lack of concentration, and aggressive behavior.

It became clear that the effects of trauma involved every Palestinian in the Gaza Strip mandating large-scale interventions to overcome both the short-term and long term consequences of trauma.

This was clearly due to the continuous exposure to violence and traumatizing incidents after the outbreak of Al Aqsa Intifada in September 2000 in response to these incidents the Gaza Community Mental Health Programme decided early in-Nov 2000 to establish a Special Committee on the Place of Crisis Intervention. The broad aim of the program was to counteract the effects of acute traumas on the Palestinian population. As part of its activities the committee commissioned activities covering the primary, secondary, and tertiary prevention levels.

Implementation to mental health of traumatized Palestinians

A pleasing issue is that the general principles of prevention as formulated in other health areas apply equally to psychiatry despite, as yet, incomplete knowledge about the etiology of many disorders. As psychiatric disorders may have multiple causal pathways, direct approaches to prevention of causes are likely to have diffused effects across several disorders, but such efforts are nevertheless worthwhile.

It has been argued that, while this model of prevention is quite useful where specific diseases or other causal factors are easily identifiable, it is less helpful in the field of mental health where precise definitions and specific disease entities with known etiologies are the exception rather than the rule. However, these arguments would only seem to hold up in relation to **primary prevention**; they do not militate any more against secondary and tertiary prevention than in physical medicine.

In the case of dealing with trauma, the cause is clear but can it be preventable?

Primary prevention encompasses activities which are directed towards specifically identified vulnerable high risk groups in the community who have not been labeled psychiatrically ill and for whom measures can be undertaken to avoid the onset of emotional disturbance and/or enhance their level of positive mental health. Thus, prevention, by this definition, is directed at specific targets rather as well as the whole population. Thus it would include indicated and possibly selective measures and certainly universal measures.

One of the major challenges to our activities was **targeting**. In order to clarify the issues surrounding targeting it is necessary here to introduce two further definitions (Gordon, 1983).

Universal prevention Activities are those which are regarded as desirable for everyone, and the decision to implement them is taken if their benefits clearly outweigh the costs and risks of implementing them.

These include activities that are directed to the general public regardless of the amount of trauma they heave been exposed to. These activities included public awareness activities directed through mass media-live TV programs addressing psychological sufferings commonly seen at times of war and ways of handling them both with adults and with children. Topics that were covered here included;

- Sleep disorders after Trauma exposure
- Enuresis as a reaction to trauma
- Overcoming Stress
- Somatic symptoms seen after crisis

In addition to that public awareness publications were distributed through the whole Gaza strip-these publications included brochures against the stigma encouraging people to consult the mental health professional when necessary, others were directed to educate people to handle different symptoms seen in childhood.

In addition training courses were carried out to school counselors, teachers and volunteers about stress handling

and dealing with children under difficult circumstances.

Micro vs. macro proactive primary prevention

There are different levels of intervention, especially in relation to proactive primary prevention, which can be classified on a continuum ranging from micro to macro, which Catalano and Dooley (1980) have condensed into two broad categories of the macro-environment (social and large organizational conditions) and the microenvironment (family and individual characteristics).

At the microlevel, proactive prevention might take the form of education about parenting to reduce the occurrence post-traumatic reactions after exposure to trauma which is done during home visits.

At the macrolevel, proactive prevention involves media education to enhance good child rearing practices and support from society to victims.

In general, people have been optimistic about microlevel prevention at the family level, but have avoided thinking about macrolevel prevention. This has arisen because conditions such as unemployment, political violence, poverty and so forth are not always regarded as within the purview of mental health, and Palestinian psychiatry has tried to learn from the lessons of the 1960s and '70s when some psychiatrists went far beyond their areas of expertise to treat the community as the patient. Also, such considerations may sometimes involve sufficiently controversial social values that it is deemed politically wise to avoid them.

Thus the general view seems often to be that microlevel proactive and reactive primary prevention approaches are helpful, while macrolevel proactive prevention is regarded as beyond the province of the mental health worker. But recently psychiatrists are trying to be involved in decision making giving rise to large-scale prevention of the occurrence of violence. The Challenge is then, Can They Be Successful? Great help is needed from international organizations so that they can play significant role in political decisions making.

Selective prevention measures are deemed to be appropriate when an individual is a member of a subgroup of the population whose risk of becoming ill is above normal.

"Indicated" measures for groups at sufficiently high risk, for groups who have experienced severe, clearly defined emotional stress (e.g. children exposed to disasters or to violence, families of martyrs, injured people, people living near shelled centers etc.).

For these people primary prevention measures are carried out which include family education, and relaxation training.

But most of selective measures are considered as secondary prevention.

The debate about **secondary and tertiary prevention** has focused on whether they qualify as "prevention" proper at all, rather than simply aspects of good clinical practice (e.g. Bower, 1987; Newton, 1988). (Indeed this viewpoint illustrates how little doubt there is of the effectiveness of secondary and tertiary prevention.) My opinion is that they do qualify as prevention simply because they do prevent something. Secondary prevention shortens the duration of illness, and hence prevents chronic morbidity and even mortality, as well as preventing some of the knock-on consequences of depression to other people, e.g. to children and spouses.

At this level many early intervention activities have been carried out. These activities include **home visits** to areas exposed to shilling, demolition or infiltration as well as families of martyrs and injured people.

During theses visits debriefing as well as psychoeducation are carried out. These are to some extend are screening visits as cases needing prolonged interventions are discovered and referred to the clinic.

Risk factors for development of acute stress disorder and posttraumatic stress disorder include

They are considered as main target aimed for intervention

- Persons who lost a loved one
- Individuals who suffered injury
- Persons who witnessed horrendous images
- Persons who had dissociation at the time of the event
- Those who experience serious depressive symptoms within a week and lasting for a month or more
- Individuals with numbing, depersonalization, sense of reliving the trauma, and motor restlessness after the event
- Those with preexisting psychiatric problems
- Persons with prior trauma
- Loss of home or community
- Extended exposure to danger
- Toxic exposure
- Individuals with a lack of social supports or whose social supports were also traumatized and are unable to be adequately emotionally available

Signs the patient needs help

- Task-oriented activities are not being performed.
- Task-oriented activity is not goal-directed, organized, or effective.
- The survivor is overwhelmed by emotion most of the time.
- Emotions cannot be modulated when necessary.
- The survivor inappropriately blames himself or herself, and the self-blame generalizes to the entire self.
- The survivor is isolated and avoids the company of others.

Another intervention on the secondary level is hospital visits; here victims exposed to injuries are seen and debriefed. Also screening is done for cases needing further intervention.

These activities are carried out 48 hours after the incident as debriefing is mandated at this period.

Apart from the immediate intervention activities, the trauma counseling program of GCMHP does School Based Interventions or Short Term Interventions, here the team members make visits to schools known to be at an area affected by any form of violence. The intervention then will take 3 steps:

Step 1: Coordination and needs assessment are done
Step 2: Teachers are given a lecture concerning detection and handling Traumatized Children.
Step 3: Brief school session is carried out as follows:

Brief school intervention

Intervention lasts 1–2 hours and uses 4 therapists per class. Teacher is present, and parents are informed.

- Introduce the therapists and ask students to guess why they have come to the classroom.
- Explain that therapists have come to talk about the disaster and encourage students to share what they know for 10–30 minutes; validate correct information; be calm.
- Have children draw, while therapists circulate and ask students to tell them about their drawings.
- Reassure students that their symptoms are normal and will ease, that people have different symptoms, that disasters are rare, and that teachers, parents, and counselors are available to help them.
- Thank the students and teachers and redirect their attention to learning.

Tertiary prevention minimizes handicap and disability and thus prevents many of the associated sequelae of chronic illness.

Here we deal with cases that already established disorder and in need of prolonged intervention. Mostly these cases are referred to the clinic and long-term psychotherapy and medications are indicated here.

This intervention can also be considered as secondary as it prevents the complications of PTSD.

Cognitive behavior therapy

Individuals are aided by the following:

- Seeing that people are concerned about them
- Learning about the range of normal responses to trauma and hearing that their emotional reactions are normal responses to an abnormal event (rather than a sign of weakness or pathology)
- Being reminded to take care of concrete needs (food, fluids, rest)
- Cognitive restructuring (changing destructive schema, such as "having fun is a betrayal of the injured," "the world is totally unsafe," "I am responsible for the disaster," or "life is without meaning," to more constructive ones)
- Learning relaxation techniques
- Undergoing exposure to avoided situations either via guided imagery and imagination or in vivo

Severe, relatively common destructive cognitions may arise after a traumatic event and need to be addressed. On the left side of the table are malignant schema that an individual may have after a traumatic event. On the right side are more constructive schema that a clinician can suggest the individual consider (Table 1).

In addition to that medications can be sometimes mandated to overcome the symptoms of arousal, such as propranolol, benzodiazepines, and alpha-agonists, and may reduce the future development of PTSD. Diphenhydramine may be helpful for sleep. If these agents are inadequate, valproic acid may be useful. Atypical antipsychotics may also be necessary.

- Propranolol: May limit hyperarousal and thereby perhaps decrease possibility of PTSD developing.
- SSRIs: SSRIs can be helpful in dealing with anxiety, depression, and avoidance.
- Benzodiazepines: May limit hyperarousal and perhaps decrease possibility of PTSD developing. Continuous administration may interfere with grieving and readaptation, because they interfere with learning. Longer acting agents are particularly beneficial when medication is administered at the emergency site.
- Antihistamines: No controlled studies are available to evaluate efficacy in separation anxiety disorder; however, possible adverse effects include a decrease in sleep latency and awakenings in mid sleep.

Table 1. Cognitive interventions

Malignant schema	Constructive schema
Life has no meaning.	Right now it is hard to make sense of what happened.
I can't go on.	What happened is very painful. It is hard but will get easier in time.
I behaved terribly.	I was frightened and unsure what to do and made some bad choices.
The world is unsafe.	Disasters are rare. Many things can be done to protect my safety.
I'm losing my mind.	Feeling confused and overwhelmed after a traumatic experience is common.
It was my fault it happened.	What was done to me was a crime.

A multidisciplinary approach

In all fields of medicine preventive activities involve a wider framework than simply those who undertake treatment, and include workers in the fields of public health, education, public policy and the political arena. In psychiatry, prevention also involves those in the social and psychological disciplines. Psychiatrists can make useful contributions in care and aftercare of patients so as to avoid subsequent consequences such as disability, recurrence and suicide, in the management of mentally disordered offenders and potential offenders, and in the education of others. The other members of the multidisciplinary psychiatric team, including psychologists, psychiatric nurses and community psychiatric nurses are also of crucial importance in applying preventive strategies.

There is a need for education of school counselors, postgraduate education of psychiatrists, general practitioners, teachers and other mental health workers, other kinds of staff members in appropriate settings, and the general public. Some of these aspects are within professional education; some are aspects of health education to the general public. Education of the public is needed about mental disorder, availability of local treatment facilities, and facts to lessen stigma. In respect of some other educational activities aimed at developing more mentally healthy life styles, coping mechanisms, and positive mental health, caution and evaluation as to real benefits are required.

Preventing the risk factor and improving the coping response: a distinction

Catalano and Dooley (1980) have distinguished, within primary prevention,

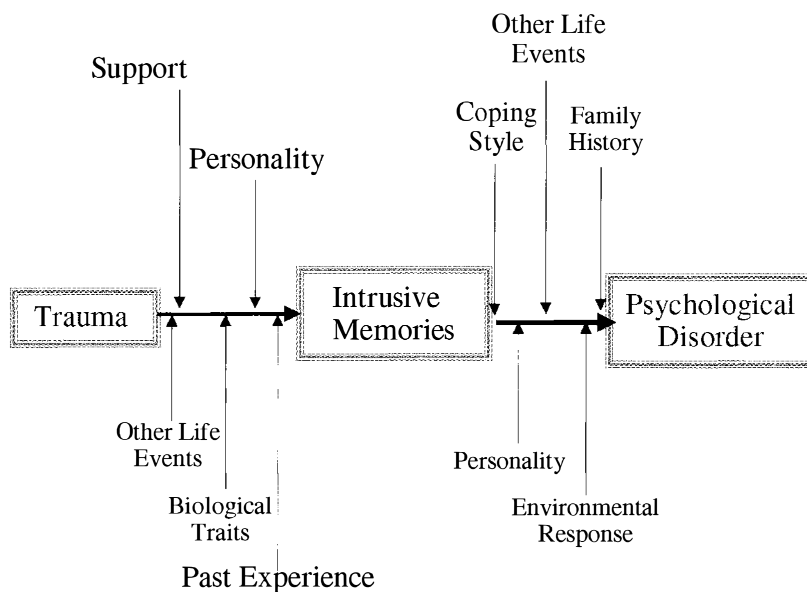

Fig. 2

between preventing the occurrence of the risk factor and improving the coping response triggered by stressors. The first strategy assumes that it is possible to control or prevent the occurrence of the causal agent while the second strategy assumes that the agent, is unavoidable, can be resisted. They cite the Public health examples of eliminating breeding grounds of malaria-carrying mosquitoes as preventing occurrence of the risk factor, and vaccinating for Polio and smallpox as improving the coping response triggered by stressors, and they have termed the first approach "proactive primary prevention" and the second "reactive primary prevention". Reactive primary prevention can occur before or after the stressor, but is aimed at preparing the individual to react effectively to the stressor. In contrast proactive primary prevention attempts to avoid the stressor altogether (Fig. 2).

Strategies based on life event and social support theory

Important factors attenuating the effects of stress include the availability of social support or a helping social network for people undergoing life stressors, and social competence or coping ability and style. Both factors lend themselves to the development of preventive strategies.

Developing natural support systems

Facilitating the development of natural support systems in the community relies on the evidence that social supports act as a buffer protecting individuals from the effects of external stressors (Cassel, 1973; Caplan, 1974; Bloom, 1979). These strategies may be further categorized:

a) Supporting existing providing consultative services to natural support systems
b) Creating a new but natural support system. E.g. self-help groups
c) Educating carers. The knowledge and skills of professional and non professional carers can be improved so that they will be more effective in the future (Caplan, 1970).
d) Organizational consultation. This aims to create more responsive organizations. This is based on the premise that schools, social services and other key organizations have a profound effect on attitudes and behavior, and are not neutral in their influence (Maclennan et al., 1975).
e) Development of alliances. Coalition building aims to develop community networks to bring together the relevant agencies, and also to increase the community's involvement in health issues. The community may then start to develop on advocacy role as well, arguing for more resources, lobbying for support and so forth.
f) Mental health education. This is aimed at several different levels. Mental health education seeks to inform the general public about mental health problems and about available treatment and health promoting resources.

It is particularly important to reduce stigma, and here, school and the media have an important role; it aims to develop important competencies within normal and at risk groups, in order to improve the capacity to cope both with predictable life transitions and with less predictable stresses. The premise is that disorders can be avoided by strengthening an individual's or group's capacity to handle environmental stress or life issues (Cowen, 1977); it can be used to increase the knowledge and skills of both patients and their relatives; and can be specifically targeted by providing important information to people a community who are in key positions to affect lives of others – formal and informal, such as clergy, teachers, employers and doctors. Lastly, it is important to influence public policies which affect the mental health and well-being of individuals and groups in the community. Keeping policy makers informed about mental health issues and sensitive to the effects of service programmes on human lives, and developing position pape on key policy issues, are among the strategies open to health promotion professionals who wish to influence the public policy process.

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