

## Highlights of this issue

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### **The British Journal of Psychiatry and the World Psychiatric Association: bringing the toll of disasters and trauma on mental health to the forefront of psychiatric discussion and practice**

It is an undeniable fact that mass migration because of wars and racial or religious persecution has become a main global characteristic of the first three decades of the current millennium. With this development comes major challenges to the mental health of those who are subject to persecution, to those who have to flee their homelands, to those who suffer from brutal violations of fundamental human rights, but also to their caregivers. Most fittingly, the 2017–2020 Action Plan of the World Psychiatric Association (WPA) is aimed at strengthening the contribution of psychiatrists to reducing distress, illness and suicidal behaviour among vulnerable populations. This also entails training and support for psychiatrists to work effectively with all decision-making bodies and community-based mental health systems.

It is in this spirit that the *British Journal of Psychiatry* has teamed up with the WPA to discuss various mental health aspects of disasters and trauma in this special issue. This themed issue has also been inspired by the recent WPA-co-sponsored international conference ‘East meets West: Exchange and Interaction of Global and Local Psychosocial, Psychotherapy and Psychotraumatology Methods between Middle East and Western Countries on psychosocial, psychotherapy, and psychotraumatic methods’ that took place at the University of Duhok in Kurdistan (23–24 June 2019).

Here, we briefly summarise the main messages of the ten papers in this special issue, covering a highly diverse range of topics relevant to the work of psychiatrists, psychologists and other mental health experts around the globe.

### **Cloitre: ICD-11 complex post-traumatic stress disorder: simplifying diagnosis in trauma populations**

Cloitre (pp. 129–131) contrasts the diagnostic classification of post-traumatic stress disorders in DSM-5 versus ICD-11. As regards DSM-5, she highlights the problems in assessment and treatment planning that have arisen as a result of an expansion of symptom clusters available for making a diagnosis. She discusses ICD-11’s approach to tackle symptom heterogeneity by defining two disorders, post-traumatic stress disorder (PTSD) and complex PTSD (CPTSD), the latter including not only PTSD symptoms but also disturbances in emotion regulation, self-identity and relational capacities. Cloitre points out that there is enough empirical evidence to support the discriminative validity of PTSD and CPTSD. Despite this apparently well-founded distinction, she highlights the importance of more research to understand the relationship between CPTSD and borderline personality disorder; to dissect the biological and environmental factors contributing to a person displaying PTSD rather than CPTSD or vice-versa; and to develop optimal treatment strategies accounting for the apparent distinction between the two disorders.

### **Murphy et al: Validation study of the International Trauma Questionnaire to assess ICD-11 post-traumatic stress disorder (PTSD) and complex PTSD in military personnel**

Murphy and colleagues (pp. 132–137) validate the measure of ICD-11 PTSD and CPTSD, the International Trauma Questionnaire

(ITQ), and assess the rates of the disorder in treatment-seeking UK veterans. They could show that in comparing PTSD with CPTSD that CPTSD was more strongly associated with childhood trauma than PTSD.

### **Medjkane et al: Childhood trauma and multimodal early-onset hallucinations**

Based on previously reported evidence that early trauma increases the risk of psychotic experience, Medjkane et al explore the relationship between the multimodality of hallucinatory experiences and childhood trauma (pp. 156–159). Studying 75 children and adolescents who were seen at a clinic specialising in early-onset hallucinatory experiences, they found a significant link between a history of childhood trauma and the number of sensory modalities involved in hallucinations. In conclusion they emphasise the need to routinely screen for traumatic events in childhood when multimodal hallucinations are present.

### **Bisson et al: Evidence-based prescribing for post-traumatic stress disorder**

Although pharmacological approaches are only recommended as second-line treatment options in PTSD, in reality, medication is widely prescribed for this disorder, as Bisson et al point out (pp. 125–126). Hence, the authors argue for the need to work towards an evidence-based prescribing framework. Reminding the reader of the inherent difficulty in directly comparing results of randomised controlled trials of psychological and pharmacological treatments, they argue that the true magnitude of benefit for pharmacological interventions may be higher than typically reported in the literature. Although the evidence is best for fluoxetine, paroxetine, sertraline and venlafaxine, Bisson et al emphasise that there is still a lack of sufficiently detailed guidelines. To aid clinicians, they have developed the Cardiff PTSD Prescribing Algorithm that encourages a measurement-based approach, provides information on side-effect profiles, monitoring requirements and other aspects a clinician would typically benefit from.

### **Jones: Moral injury in a context of trauma**

Jones’ editorial talks about a mental health disturbance that is not yet widely known to the psychiatric community-at-large: moral injury (pp. 127–128). Originally introduced as ‘moral distress’ to describe how nurses feel when they are prevented from acting in what they believe to be an ethical manner by institutional regulations, moral injury is not just a classical ethical dilemma but, here, the individual is subjected to the mercy of events without having an influence on them. Although moral injury is not formally classified as a mental illness, it has been suggested to be at the heart of the enduring nature of PTSD experienced by Vietnam War veterans. Jones discusses in depth why moral injury has not yet found its way into classification systems. Citing a recent body of research, however, Jones underscores that potentially morally injurious experiences account for up to 10% of the variance across various psychiatric disorders.

### **Goodwin et al: Psychological distress after the Great East Japan Earthquake**

This is a three-level prospective study examining associations between survivors’ psychological distress and individual and social factors in a multilevel approach (distress and time, pre-existing disorders and disaster experience, and city-wide measures of support and physical activity). Goodwin et al’s (pp. 144–150) 6-year prospective study following this natural disaster uses two large samples of residents from two different types of housing

(private housing or prefabricated housing). Through a complex statistical analysis they found a relatively low level of psychological distress considering the high levels of destruction experienced by the sample and the already high levels of distress recorded in the district prior to the earthquake. It shows also that post-earthquake distress diminished with time but varied with gender, psychiatric history, housing, levels of activity and availability of social support. It therefore sheds some new light on the importance of taking these factors into account to design effective interventions in such situations.

#### **Beaglehole et al: Impact of the Canterbury earthquakes on dispensing of psychiatric medication for children and adolescents**

Relying on routinely recorded dispensing data from community pharmacies in the Canterbury, New Zealand earthquakes area, Beaglehole et al (pp. 151–155) analyse the dispensation of psychiatric medication for children and adolescents as an indicator of their mental health status. This creative approach shows that the dispensation of psychiatric medication for children and adolescents did not increase during this period, meaning that, in children and adolescents, the incidence of mental disorders or psychological distress of sufficient severity was not substantially increased as a consequence of the Canterbury earthquakes. It also raises interesting considerations about the relationship between mental health status and psychiatric medication for children and adolescent in such traumatic contexts.

#### **Kizilhan et al: Shame and dissociative seizures and their correlation among traumatised female Yazidi with experience of sexual violation**

In this study, Kizilhan and colleagues (pp. 138–143) could show that women who were held captive by ISIS had significantly higher

prevalence of dissociative seizure, somatoform, depressive and anxiety disorders than women who were not held captive and sexually abused by ISIS. They also showed that women having experienced sexual violation and with PTSD had significantly higher scores on shame, dissociation and somatoform disorder than the women with PTSD who were not sexually violated. Shame in connection with sexual violence seems to play an important role in a negative self-perception after rape. Dissociations play an important role in more recent trauma experiences with shame and should alert clinicians to psychiatric diagnostic and treatment.

#### **Danese et al: Child and adolescent mental health amidst emergencies and disasters**

Analysing scientific literature on mental health of children and adolescents exposed to emergencies and disasters, Danese et al (pp. 159–162) advocate improving the preparedness of mental health services for children and adolescents to, ultimately, mitigate harmful effects of emergencies and disaster in this most vulnerable population.

#### **Duchonova et al: Psychosocial care of immigrants in the Czech Republic as a country in transition**

In their commentary, Duchonova et al (pp. 163–164) portray how the recent waves of migration and forced displacements have been received in a prototypical former Eastern European country. The authors note a lack of State and academic interest in this issue, which they see as a burden to providing the necessary relief for this humanitarian crisis. They urge the community of mental health professionals in the Czech Republic to educate the public about the undeniable mental health needs of the highly traumatised refugee populations, which in their opinion could also lead to protective non-stigmatising legislation.