Correspondence

Smoking and mental health

Sir: Hamid Ghodse's excellent editorial in the January 2007 issue of *International Psychiatry* omitted one aspect of the smoking disease in mental health services – the political. On a global scale, it is clear that the tobacco multinationals must recruit very large numbers of new smokers each year. This they do increasingly by targeting low- and middle-income countries, and, within these countries, especially the young and the poor.

In the West, smoking is now a marker for poverty and most psychiatric patients are poor. So also are their care staff, particularly untrained nurses, who are some of the lowest-paid workers in Western society.

Smoking has become not only a class identifier of the dispossessed, but, however much we hate to admit it, a valued habit of poor workers, whose threatened loss causes alarm and resentment. None the less, it is an ethical imperative to stamp out smoking. To fail in this is to collude with the exploitation of poor patients and staff, as well as to fail our medical duty. To cite 'human rights' as a reason for retaining the truly squalid 'smoking rooms' in hospitals is legally incorrect. Article 2 of the European Convention prohibits the taking of human life and consequently the promotion of any activity that risks it. Article 3, which relates to inhuman or degrading treatment, may also be invoked. These are both absolute directives, and both they and our own Hippocratic command from antiquity to do no harm outweigh Article 8, the right to private and family life, which is broadly defined and not absolute, but conditional upon, among others, measures for 'public health'.

The political aspects must therefore be understood. The fight against smoking has to be on a global as well as on a local front. The multinationals must be confronted. The exploitation of health workers must be addressed and fair wages paid. Closing the smoking rooms is another step in normalising psychiatric patients and reducing stigma as well as improving health. The sensibilities of the staff who interact most directly with patients, and whose input is grossly underestimated, namely untrained nurses, must be understood. Smoking is a means by which we are all potentially exploited by large capitalist enterprises.

Incidentally, a physician colleague used to confess his wonderment to me that psychiatrists continued to treat schizophrenia by the use of 'kippering rooms'.

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Psychological trauma training in Lebanon

Sir: Ten days after the 33-day war between Lebanon and Israel, in July 2006, I was able to arrange a psychological trauma training (PTT) visit to Lebanon with the Qatar Red Crescent. (I have done similar work in the past in the West Bank, Gaza, and Kashmir after the earthquake of October 2005.)

We trained two groups, in Saida and in Sour (Tyre), each over 2 days. Trainees included medical, nursing, paramedical and ambulance staff, as well as social workers, psychologists and Lebanese Red Cross staff.

There were 31 people in the first group. The first day focused on the nature of disasters, human psychological reaction to trauma, defence mechanisms, post-traumatic stress disorder (PTSD) and means of support, both medical and non-medical. There was great interest from the group in the non-medical techniques, especially drawing and painting. Drama was popular with everyone. In groups of ten, they created a drama on the Lebanese family before and during the war, and in the future. It was both fun and educational. There was excellent interaction between trainees, and the feedback was very positive from the group.

On the second day, the morning sessions focused on PTSD in children. The afternoon session was allocated to 'helping the helper', and burn-out syndrome, the hidden trauma for those involved in relief work, and how to take care of ourselves. Again there was very encouraging feedback from all trainees. All were grateful for the PTT and requested further training. At the end we distributed certificates of PTT to participants, acknowledging their effort. I was very much touched by the trainees' enthusiasm and commitment considering that they are just coming out of a war.

The second group was in the city of Sour. Trainees were more traumatised than the group in Saida, possibly because Sour was hit very badly by Israeli jets. All trainees except two had some symptoms of psychological trauma, including anxiety to noise, sleep difficulties, nightmares, indifference and loss of interest.

I did an interview with a local Lebanese television station, on the psychological effects of the war. On such PTT visits I normally give great importance to any television or radio interview in order to send the message out to the wider community on the psychological effect of trauma, how to cope and how to help children in particular. My two main messages on the interview were:

- Don't ignore the 'elephant in the room' (the war in the case of Lebanon) – talk about it.
- Whatever you are feeling as a reaction to the war, this is a *normal* human reaction to an *abnormal* situation, which is the war, and not the other way round, as most affected people think.

I hope this brief account will be of interest to readers of this journal and would welcome any comments and feedback.

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A full five-page report is available from the author via email: Mamoun.mobayed@nwb.n-i.nhs.uk