You are the indigenous healer

HEALING THE WOUNDS OF MASS VIOLENCE

REFUGEES, ASYLUM SEEKERS, AND CIVILIAN SURVIVORS OF MASS VIOLENCE AND TORTURE

Harvard Program in Refugee Trauma

Massachusetts General Hospital

www.hprt-cambridge.org

As a primary care provider, you can heal the psychological effects of mass violence and torture by addressing patients' mental health needs. You are an **indigenous healer** in your society, along with clergy, elders, and folk healers. Studies show that in times of distress or crisis, most citizens will seek out their indigenous healers, especially their primary healthcare practitioners.

The PCP is an agent in creating a protective social response to mass violence

The primary care provider (PCP) must be prepared to deal with the acute and long-term mental health effects of mass violence. Not only will the primary healthcare system be the first line of medical defense for those who experience trauma, it will also be called upon to contribute to the psychological recovery and resiliency of the entire society.

While the UN states that it is currently providing assistance to millions of refugees and displaced persons worldwide, HPRT estimates that approximately ½ billion persons continue to suffer from the physical and mental health aftermath of trauma in more than 60 nations. These populations, which include refugees, asylum seekers, and civilian survivors of mass violence and torture, are seeking relief from their suffering from their indigenous healers.

There is considerable overlap in the mental health care of survivors of different types of mass violence. For example, while all refugees have been traumatized to some degree, not all refugees have been tortured. Civilian survivors of mass violence are often citizens who do not become refugees, displaced persons, or prisoners subject to physical and mental torture. And asylum seekers who flee in fear for their lives may not be survivors of mass violence or torture. What they all share, however, is exposure to life-threatening danger, loss of control over their lives, persecution, and the experience of violence, often of unspeakable horror and cruelty.

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els of psychiatric illness as they relived their original trauma experiences. Others feared for their further safety. In some refugees and torture survivors, regression to a prior state of psychosocial disability was prominent, including fear of returning to work and barricading themselves in their homes. Ongoing medical problems also became more difficult to manage as symptoms increased.

4. Greater risk for medical illnesses exists.
Epidemiological studies have revealed that all organ systems are relatively affected by mass violence and torture. The chronic disabling depression common in refugee survivors has been demonstrated to place them at greater risk for diseases such as diabetes, hypertension, and cardiovascular disease including stroke. The prior trauma or torture associated with the pre-migration experience, the refugee camp tenure, and the serious long-term stress of adaptation to a new lifestyle and culture place a considerable health burden on resettled refugees. Similarly, refugees who return to their country of origin often return to chronic states of poverty, discrimination, and ongoing violence. For almost all survivors of mass violence, post-traumatic stress is never "post," but ongoing.

A complete overview of HPRT's approach to the clinical care of refugees and torture survivors is available at **www.hprt-cambridge.org**.

A complete overview of HPRT's approach to the clinical care of trauma survivors is available at **www.hprt-cambridge.org**. This overview gives a comprehensive summary of HPRT's integrated medical and psychiatric model, developed over twenty years of experience with refugees, asylum seekers, and civilian survivors of mass violence and torture. The basic principles underlying the following 11 points are also more extensively described on this website, as well as on the enclosed CD-ROM entitled "Healing the Wounds of Mass Violence."

1. ASK about the patient's trauma story.

The medical interview must include asking the patient about his or her traumatic life experiences. This question may come after you have heard the patient's chief complaint. In many situations, this question will clarify the chief complaint.

It is our experience that traditional open-ended questions such as, **"Can you tell me what happened to you?"** usually yield little information. This might be because the patient is too emotionally overwhelmed by his or her traumatic history to give a response. Instead, we suggest that you use a question that you feel comfortable asking all of your patients, like:

"Many of my patients feel that their experiences of mass violence or trauma have had a major impact on their health and well-being. Has this been the case for you?"

Or, an even more specific question, such as:

"Did you experience the death or loss of a loved one during the period of mass violence?"

Surprisingly, asking the patient to respond to a specific list of trauma events (similar to a medical review of systems) is the most effective way to obtain the patient's trauma history. The only area in which difficulty may occur is eliciting a history of sexual abuse. Because of the stigmatizing nature of sexual abuse in many cultures, the survivor (male or female) often

chooses to keep it a secret even from the doctor. The context of the patient's history (for example, having been attacked by Thai pirates), findings of the physical exam (such as sexually transmitted infection), or a report by the patient of witnessing rape or other sexual violence are clues to the possibility that sexual abuse may have occurred.

> The simple act of listening can be very therapeutic

The PCP should not be afraid to ask survivors about their trauma history. Most patients who have experienced some form of trauma generally appreciate having the chance to tell their PCP about what happened to them. We call the telling of traumatic events by the patient the **"trauma story."** Sometimes PCPs worry that by asking about the trauma story, the patient will take up a lot of the visit time telling the story, they will open up "Pandora's box," or the patient will become upset by revealing his or her experiences. In our experience, these consequences are uncommon. First, the aim should be to obtain the details of the trauma story over a number of visits, since the patient's trauma story might be extensive and telling the story may be upsetting to both the patient and the PCP.

Secondly, patients often deeply appreciate that their PCP has allowed them to share their traumatic life experiences and has listened to their worries and concerns. This simple act of listening can be very therapeutic. It certainly builds greater trust with the patient, and it allows the PCP to put the patient's chief complaint in context and understand the effects of the trauma on other health conditions.

Once the PCP opens up the trauma story during the medical interview, the practitioner may not know how to end the interview without upsetting the patient or abruptly terminating the discussion. Point 10 addresses concrete and productive methods for closing the discussion.

Customizing the 11 Points

These 11 points should be customized for PCP settings that have special patient populations or clinical needs. Every PCP environment should modify these 11 points to maximize their cultural sensitivity and clinical effectiveness.

For example, in over twenty years of experience with refugees and survivors of torture, HPRT has found the following general principles to apply specifically to the care of these groups:

1. Refugees and torture survivors are at greater risk than the mainstream population for developing mental health problems like generalized anxiety disorders, depression, and PTSD. Scientific studies have revealed a significant dose-effect relationship between cumulative trauma and psychiatric illness and disability. In other words, the more trauma events a survivor has experienced, the greater his or her probability of developing psychiatric morbidity.

2. Certain traumas are more "toxic" to survivors than others. A number of studies of populations experiencing mass violence have revealed that the following trauma events are extremely potent in producing adverse mental health effects:

- head injury
- physical injury
- disappearance of a loved one
- death of a child, and
- torture, or the systematic use of physical and mental abuse against someone who is incarcerated by the perpetrator(s).

3. There is ongoing vulnerability to new encounters with violence. The refugee and the torture survivor are especially sensitive to new encounters with violence. For example, refugee patients, asylum seekers, and torture survivors in the United States had dramatic and negative medical and psychological reactions to the terrorist attacks of September 11th. Many fell back into their pre-treatment lev-

11. PREVENT BURNOUT.

Acts of mass violence directly affect the practitioner as well as the patient. As members of the community, PCPs can suffer from the same mental health consequences of trauma as their patients. Medical personnel are also subject to greater risks through their professional roles. For example, healthcare institutions are sometimes specifically targeted by terrorists and other perpetrators of mass violence.

There is evidence that long-term involvement in care of civilian survivors of mass violence is extremely stressful to PCPs, leading to the state of chronic stress and fatigue known as "burnout." Confronting the horror of individual patient's trauma stories and suffering over and over again can affect the practitioner's own health and ability to function effectively at work.

PCPs caring for patients affected by mass violence need a systematic, institutionally supported plan for self-care, and time for attention to their own health, including diet and exercise. Weekly discussions of difficult cases with colleagues can be very helpful. Learning specific skills and techniques for diagnosing and treating traumatized patients reduces stress. Shifting to a "coping" versus a "problem-solving" model takes some of the burden off the shoulders of the PCP.

Acknowledgement of the stress of providing healthcare in post-conflict settings, rather than an attitude of denial, is vital.

2. IDENTIFY physical and mental effects.

The trauma story will usually provide the PCP with a roadmap for identifying health problems associated with mass violence during the review of systems and the mental status and physical examination. The PCP should be alert for any of several common presenting complaints following an experience of trauma (in addition to any overt physical injuries). Somatic complaints such as headaches, palpitations, stomach upset, and dizziness are frequently associated with psychological distress. The patient may be experiencing normal but extremely disturbing emotional states related to the events, such as fear of going outside, worry about leaving children at school, or extreme anger or grief over what has occurred. Exacerbation of existing medical or psychiatric disorders may also occur.

By identifying the concrete physical and psychological effects of mass violence, the PCP can help the patient note these effects and be reassured that they are normal and usually temporary. The patient can be advised that symptoms will eventually subside, particularly if specific coping strategies are used (see points 5-7).

Patients with pre-existing psychiatric disorders that worsen following trauma related to mass violence or torture may need adjustment in medications and increased psychosocial support. This is especially true for patients with prior post-traumatic stress disorder (PTSD) who may experience flashbacks, memories, and nightmares from a past, unrelated traumatic life experience.

The PCP should also always consider the possible presence of head injury in patients who are not responding to the recommended treatment approach for PTSD and depression. Head injury is an especially common trauma in torture survivors specifically, with serious medical and psychiatric consequences. It is not unusual for torture survivors to have been severely beaten on the head with bamboo poles, guns, fists, etc. Often coma may not occur at the time of head injury,

especially if it is chronic and repetitive. The symptoms of post-concussive syndrome will usually have been present. The patient may be unaware of lingering medical and psychiatric effects of head injury. Current head injury sequelae will often be masked by symptoms of depression and PTSD. Neurological examination and neuropsychological testing are useful in this situation.

3. DIAGNOSE AND TREAT grief reactions, generalized anxiety disorder, depression, PTSD, and insomnia.

After an experience of mass violence, almost everyone will experience some transient physical or psychological symptoms. These patients will benefit from counseling on the nature of their symptoms and coping techniques. A minority will develop a specific psychiatric disorder, including complicated grief reaction, generalized anxiety disorder, depression, PTSD, and chronic insomnia. This group will require additional intervention by the PCP. Be aware of the following points in diagnosing and treating these mental health problems:

- Most affected patients will have some symptoms but will not meet all of the DSM-IV diagnostic criteria for a specific disorder; some will go on to develop a serious psychiatric disorder.
- Those with more severe trauma experiences, such as torture, are at greatest risk for a mental health problem. Others at higher risk include the elderly, medically ill, and previous trauma survivors.
- Psychiatric diagnoses unique to torture survivors and refugees (such as "torture syndrome") have not been identified. The PCP can feel confident working with usual DSM-IV or ICD-10 diagnostic criteria.
- Use HPRT's Simple Screen to decide who has a psychiatric disorder requiring treatment (see HPRT's website at **www.hprt-cambridge.org**).
- Treatment includes reassurance, psychosocial support, and temporary use of medications for symptom relief.

human rights abuses warrant attention as problems in their own right, including:

1. head injury
2. unnatural death of a child, spouse, or relative
3. torture
4. sexual abuse
5. disappearance of a loved one

These events, even when not the source of the patient's current medical and psychological health problems, have an enormous impact on the doctor-patient relationship and provide a context for future care.

It is important to recognize that not all of the diagnosis and treatment can or, indeed, should be accomplished in a single session. In caring for traumatized patients, repeated brief interventions over a period of time are a more appropriate model for care than a single lengthy problem-solving session: **"a little, a lot, over a long period of time."**

The PCP should note, however, especially after first meeting a traumatized patient, that mistrust and a general feeling of hopelessness and despair often result in missed appointments. If this occurs, a follow-up phone call usually results in much better follow-up.

In our experience, highly traumatized patients successfully recover in a healthcare environment where there is brief but ongoing attention to the patient's medical and mental health problems.

Once heard by the PCP, the trauma story does not need to be constantly probed and retold. Rather, it provides the context for a respectful and trusting therapeutic relationship with the PCP. After the practitioner hears and acknowledges the trauma story, healing can occur. If the practitioner never gets to know the trauma story, treatment will proceed on a very weak foundation and will often be unsuccessful.

9. PRESCRIBE psychotropic medications, if necessary.

Use HPRT's psychopharmacology pamphlet for simple and detailed guidelines about drugs most commonly used to treat depression, generalized anxiety disorder, PTSD, and insomnia.

10. CLOSE & SCHEDULE a follow-up visit.

The PCP needs a method for sensitively closing the interview, especially after a traumatic history has been revealed. The practitioner might say, **"Thank you for telling me about these upsetting events. You have helped me to understand your situation better."** Patients are often more able to terminate a very emotionally disturbing visit than the practitioner expects. However, they need some reassurance that you listened to their trauma story, that this discussion was an appropriate part of the medical interview, and that they did not embarrass themselves by wasting your time.

Physical or emotional symptoms of trauma should be placed on the patient's problem list

In closing, the PCP should try to get the patient's input on how they should work together. For example, you might say, **"How would you like me to help you?"** The answers of some patients may be very specific; others may have no idea what help they may need. You should work out a plan with the patient that includes reference to follow-up visits. Patients greatly value the PCP's assurance that they will take up again the patient's trauma story during the next visit.

Finally, the problem of physical or emotional symptoms following traumatic events should be placed on the patient's problem list and readdressed in subsequent visits. Because of their potency, certain specific trauma events resulting from

Grief reactions. Grief, mourning, and bereavement all refer to the subjective feelings experienced by those who have lost a loved one. In times of violence and conflict, grief reactions can also be caused by the perceived threat and humiliation following the death and injury of fellow citizens, destruction of property, or assault on a nation's pride and security.

Normal grief is initially manifested by a state of shock or disbelief and feelings of numbness and bewilderment. This state is usually followed by expressions of suffering, such as crying, often associated with poor sleep, loss of appetite, physical weakness, extreme fatigue, and poor concentration. The patient experiencing grief may constantly relive memories of those who have died as well as re-experience the associated traumatic events. They may feel remorseful or guilty that they could not prevent the death or traumatic event. Sometimes the patient feels hopeless about the future and the ability to go on living. Different cultures will manifest the emotional intensity of grief in different ways, ranging from a "stiff upper lip" to outpourings of emotional distress.

The PCP must acknowledge the grief and assure the patient that their symptoms will subside over time. Because the patient must go through the grief process, medication is rarely indicated unless a serious depression occurs or the grief process does not follow a normal course of eventual remission. During subsequent visits the PCP should be on the lookout for a pathological grief process that is not resolving. Those who had a sudden loss, are socially isolated, or had a poor relationship with the deceased are at risk for a complicated bereavement.

Generalized anxiety. Experiences of conflict and mass violence create a climate of fear and terror in society. And where there is fear, anxiety soon follows. Anxiety is an alerting signal similar to fear that warns the patient against impending danger. Once the real threat recedes, anxiety can continue as an internal state of emotional distress in response to a vague or unknown threat.

All human beings experience anxiety at some time in their lives. During times of crisis, anxiety becomes a universal phenomenon, characterized by an unpleasant sense of apprehension, dread, and nervousness and often associated with autonomic symptoms, such as headache, dizziness, palpitations, diarrhea, upset stomach, and restlessness.

Relaxation techniques and coping strategies can help all patients affected by generalized anxiety

The PCP will see states of anxiety related to mass violence on a continuum from very mild to severe and socially disabling. Relaxation techniques and coping strategies can help all affected patients; medication may be useful in severe cases. If anxiety symptoms remain unchanged or have worsened after six months, the patient may have developed a generalized anxiety disorder (per DSM-IV criteria). The development of panic attacks or agoraphobia may also occur.

Depression. Depressive symptoms are common in the aftermath of mass violence. Patients may feel sad about the tragedy they have personally experienced or witnessed. They may also feel hopeless about the future. Depressive symptoms frequently seen in primary healthcare settings include sadness or low mood, tearfulness, insomnia, fatigue, and poor concentration. Patients may have a masked depression, that is, they may not realize that they are depressed until the PCP recognizes and reviews with them their depressed mood and associated symptoms.

In the immediate aftermath of conflict, reassurance and psychosocial support from the PCP may be enough for many patients. The PCP must be alert for a clinical depression developing over time in such patients. For patients who present with initial severe symptoms that meet DSM-IV criteria for major depression, medication and counseling are advisable.

patients. Failure to adjust dosage appropriately may result in higher incidence of side effects and poor adherence to treatment.

Medical interpreters. The use of medically untrained personnel or family members for translation is widely considered an unacceptable practice in providing care to patients who do not speak the dominant language in a given society. However, lack of funding and availability of suitable interpreters often makes access to trained medical interpreters difficult or impossible.

The PCP should make every effort to use a trained medical interpreter, ideally one with mental health skills and sensitive to the patient's cultural background. Male interpreters should not be involved in taking a sexual history from a female patient. Confidentiality and informed consent must always be respected and maintained. Many communities are small, and the patient may fear that the medical interpreter (whom they may know personally) will reveal their medical problems to the community. Family members may also fail to maintain confidentiality unless they are explicitly asked to do so by the PCP.

With an appreciation of the existence of folk diagnoses for many medical and psychiatric illnesses, it becomes evident that a literal medical translation of a Western diagnosis may have little meaning to the patient. The medical interpreter may be aware of this problem, but often will not challenge the PCP's authority by pointing out that the patient does not understand the meaning of the diagnosis. The PCP can ask the patient, through the interpreter, **"Do you know what I mean by this diagnosis?"** The patient can be asked to repeat back through the interpreter his or her understanding of the diagnosis and treatment plan outlined by the PCP. This brief questioning can make clear any gaps between the practitioner's understanding of the illness and the patient's perspective.

plaints among patients of different cultural backgrounds. The PCP should seek to become informed about the major symptoms of emotional distress for the groups they see most commonly in practice.

Each culture also has its own unique folk diagnoses for describing the suffering of its members. These terms for describing emotional distress are usually well known to the average person in the cultural group. Such folk diagnoses in non-Western societies are usually not medical diagnoses and often do not include an appreciation of psychiatric disorders or mental illness. Yet, some of these folk diagnoses do overlap with DSM-IV psychiatric diagnoses. Traditional and spiritual healers and elders are the first line of treatment in many such cultures. When these fail, the PCP is the next recourse. In many cultures, Western psychiatric diagnoses and visits to psychiatric practitioners are highly stigmatizing.

In many cultures, Western psychiatric diagnoses are highly stigmatizing

Since PCPs cannot know all the folk diagnoses related to emotional distress for each culture represented among their patients, they should inquire about a folk diagnosis if a mental health problem is identified using Western criteria. For example, the PCP can ask, **"In your country, what would your family or community say is wrong with you?"** The patient will often give a folk diagnosis related to emotional distress. Understanding the patient's perception of his or her condition in the context of the culture will allow the PCP to better tailor recommendations for treatment.

Ethnopsychopharmacology. Psychotropic medication prescribing should be tailored to the racial and ethnic background of the patient, since there are well-documented differences in drug metabolism and response to treatment according to race/ethnicity. For example, Asian patients generally respond well to much lower doses of antidepressants than Caucasian

Post-traumatic stress disorder (PTSD). Symptoms of PTSD are a common response to events of extreme violence. PTSD is characterized by a direct link between a violent event and its emotional aftermath, which manifests as recurrent memories, avoidance, numbness, and arousal.

Recurrent memory phenomena include flashbacks (reliving the event as if it were actually occurring), daytime memories, dreams, and nightmares that contain elements of the traumatic experience. Avoidant symptoms are present if a patient avoids thoughts, feelings, activities, or places associated with the trauma. Psychological numbness can occur, in which patients lose interest in their daily activities, feel detached and estranged from others, and feel unable to experience normal emotions such as love or friendship. Arousal symptoms include new physical symptoms that arise after the trauma event, such as insomnia, irritability, outbursts of anger, hypervigilance, and an exaggerated startle response.

After traumatic events, the symptoms of PTSD are extremely common. For most persons these symptoms subside, especially if a sense of safety is restored. True PTSD is often associated with depression. The PCP should follow patients with initial PTSD symptoms over time to make sure they do not develop full-blown PTSD or a chronic depression.

Insomnia. PCPs commonly confront acute and chronic insomnia in their daily practice. Insomnia (difficulty in initiating or maintaining sleep) has many medical and psychiatric causes that the PCP can diagnose and treat. The fear, terror, and anxiety associated with mass violence may cause a transient insomnia that is not likely to be serious or to become chronic. Specific treatment is not usually required; in severe cases, the temporary use of medication may be helpful.

It is not known how often trauma-induced insomnia becomes a chronic condition. If this does occur, it is highly likely that the patient is suffering from PTSD and/or depression.

4. REFER cases of serious mental illness.

While most trauma-related mental health conditions will recede with the help of the PCP's reassurance and psychological support, some may develop into true psychiatric disorders. It is now generally accepted that psychiatric disorders such as major depression can be routinely treated by the PCP; similar expectations hold for grief reaction, generalized anxiety disorder, PTSD, and chronic insomnia. These disorders often co-exist with other conditions, such as substance abuse, are associated with dysfunctional patterns of personal and family behavior (for example, domestic violence), and are often accompanied by serious medical problems. Brain injury due to malnutrition, past infectious diseases such as malaria, and torture may also affect the patient's neuropsychological competence.

Psychiatric disorders such as major depression can be routinely treated by the PCP

Referral to a psychiatric practitioner of any patient with a psychiatric disorder following trauma should not be an automatic response, since the PCP has much to offer such patients. If recommended approaches to treatment are not effective, however, a referral to a mental health specialist may be necessary. Referral should be considered in the following circumstances:

Danger to self or others. If a patient is acutely suicidal or in danger of hurting others, a referral or consultation should be immediately requested, including a possible emergency visit. The PCP should assess suicide potential by asking questions such as, **"Are you suicidal now?"** or **"Do you have plans to take your own life?"** A family history of suicide or previous suicide behavior places a patient at increased risk. A mental health practitioner can help assess the potential risk for violent behavior. Be alert for a history of violent acts, impulsive behavior, paranoid thinking, command hallucinations in psy-

The PCP can inquire about high-risk behaviors by asking, for example, **"Have you started to use or increased your use of cigarettes, drugs, or alcohol?"** and **"Are you having unprotected sex?"** If the response is positive, the PCP can recommend a number of steps to reduce these high-risk health behaviors.

8. BE CULTURALLY ATTUNED in communicating and prescribing

In dealing with patients affected by mass violence, the PCP needs to be aware of a number of culturally influenced clinical issues that affect diagnosis and treatment. For example, cultural issues may not be represented only by differences in linguistic and cultural backgrounds and identities, but also by age, gender, social class, and city dwellers versus rural inhabitants. For the latter reason, all societies are culturally diverse, even those with a single language and ethnic identity.

Different cultures, social classes, ages, etc. have different views of and responses to trauma. Patients who live in violent neighborhoods, for example, may be more vulnerable to the mental health effects of violence than those in safer communities. Prior history of experiencing mass violence in refugee and immigrant patients might intensify their reactions to more recent events. Patients with a history of sexual abuse or domestic violence may also react strongly to acts of extreme violence. The worldview of the patient within his or her community is extremely important in the clinical approach to survivors of mass violence. Be aware of the shame, humiliation, and stigma associated with certain types of trauma events (for example, sexual violence). Appreciating these different views on trauma will help the PCP contextualize the current effects of violence on the patient as well as culturally prescribed reactions to these events.

Folk diagnoses and emotional distress. Cultures have various ways of expressing suffering and emotional distress. For example, anxiety will manifest itself in different chief com-

conflict must be encouraged to get back to work as soon as possible. All unemployed patients should receive recommendations and support for participating in informal work activities to earn money, or for in-home or community projects. Volunteering for trauma-related activities, such as the work of the Red Cross, may also be helpful for patients who are not too avoidant of settings that directly remind them of the trauma.

Spirituality is extremely therapeutic to patients in times of personal and national disasters

Spirituality, or activities concerned with sacred or religious things, is extremely therapeutic to patients in times of personal and national disasters. Spiritual activities such as prayer or meditation are usually culturally influenced and may involve the clergy, religious institutions, or members of the patient's family or community. Or, spirituality may be deeply personal and humanistic in a more existential way, independent of a religious institution or theology.

For patients who are not religious or members of a religious institution, the PCP can encourage discussions about the meaning of the events and their reactions to the trauma with individuals they respect. Establishing a meaningful worldview on traumatic events is especially helpful in diminishing the mental health impact of trauma.

7. REDUCE high-risk behaviors.

Patients often increase their use of cigarettes, drugs, and alcohol, or become involved in high-risk sexual behavior during times of crisis. The PCP must be on the alert for these unhealthy activities. Some patients will initiate such high-risk activities for the first time in order to cope with the added stress of mass violence; others will increase activities they are already doing or to which they are predisposed.

chotic patients, a stated desire to hurt or kill others, antisocial personality disorder, the presence of dementia or delirium, and alcohol or drug intoxication.

Complicated grief. Counseling is usually needed to help a patient resolve a complicated grief reaction, that is, grief that is delayed, excessively intense and prolonged, or associated with suicidal thoughts or psychotic symptoms.

Severe forms of PTSD and/or depression. Trauma-related PTSD and depression can usually be adequately treated by the PCP over time. Referral is appropriate when symptoms persist despite treatment or when PTSD co-exists with depression or substance abuse. Psychosis associated with PTSD carries high risk for suicide or harmful acts to others and should prompt referral. Head injury is another complicating factor that may warrant specialist consultation.

Physical and social disability. Mental health conditions associated with trauma can cause moderately severe physical and social disability. Events such as loss of a job and chronic unemployment can affect recovery. Once survivors of terrorism lose the opportunity to be economically productive, they can fall into a social and financial rut that makes recovery very difficult. These patients should be identified early and social service or caseworkers immediately called in to provide assistance.

5. REINFORCE and teach positive coping behaviors.

In times of national and local crisis, people generally are self-reliant and try all types of conventional and innovative approaches for dealing with the trauma events affecting them. For example, people may try to keep busy, spend more time with friends and relatives, and seek out the advice of clergy. Patients affected by trauma are usually not interested in having the PCP solve their problems; they are primarily seeking

the PCP's advice on how they can better cope with their situation. In order to maximize the patient's effectiveness, it is helpful for the PCP to shift perspective from taking on the burden of the patient's problems to supporting the patient's efforts toward coping and resiliency.

Patients are primarily seeking the PCP's advice on how they can better cope

It is surprising how often civilian survivors of mass violence do not systematically utilize the positive coping strategies available within their own cultures (for example, Buddhist meditation and relaxation techniques). Most of the survivor's self-administered coping strategies have not failed, they just usually have not been applied in a disciplined and habitual manner. The PCP can have a dramatic impact on these patients by supporting them in not "giving up" on those coping strategies that are culturally available.

Patients usually hold their PCPs in very high regard. The PCP must take advantage of this positive regard to validate whatever coping strategies are already being used and to state unambiguously: **"Keep up the good work! It is good for you and will help you cope."** If the patient's coping strategies are not productive, the PCP can say something like the following: **"I think there are some other approaches you can take that might prove more helpful. Why don't you try the following strategies to help you cope with your situation?"** Acknowledgement of the need for coping strategies and support from the PCP can go a long way in preventing and reducing the mental health effects of mass violence.

Recommended coping strategies begin with self-care, including finding a safe and secure living environment, if necessary; reducing social isolation; increasing support from family and friends; engaging in exercise, relaxation, and anti-anxiety techniques; and developing the courage and mental discipline to overcome fear and anxiety.

6. RECOMMEND altruism, work, and spiritual activities.

Scientific studies of survivors of mass violence have repeatedly revealed increased resilience associated with altruism, work, and spiritual activities. Engaging in these activities and behaviors appears to prevent mental health problems and promote recovery from existing problems. The PCP should actively recommend these activities with, for example, the following statement:

"I strongly recommend that you work and keep busy, try to help others, and consult with your clergy or engage in spiritual activities such as meditation or prayer."

Altruism (the regard for the well-being of others as a principle of action) is an important component of recovery following mass violence or other trauma. Altruism empowers the patient by actively placing them in a helping role. The patient has to surrender the possibility of despair and social isolation promoted by crisis by forming linkages with others less fortunate than themselves. Many communities of refugees, for example, are small in size, and torture survivors may acutely feel the effects of social withdrawal and stigma often associated with torture. The PCP should focus on reducing the patient's sense of social isolation through participation in community, religious, and publicly sponsored activities. This creation of goodwill, neighborliness, and social solidarity generates a significant social good that dramatically increases the resilience of the individual, the family, and the community.

Work in times of social and emotional upset is essential to the well-being of the patient. The PCP should encourage patients to continue actively working at their jobs, focusing on work activities in spite of symptoms and worries.

Conflict and acts of mass violence eliminate jobs and opportunities for employment. The survivors cannot wait for weeks, or perhaps months, for economically productive activity to emerge for them. Those who have lost their jobs due to the