

Disaster Psychiatry: An urgent field in psychiatry posing a pertinent question

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Disasters, both natural and man-made, impose a significant burden on the mental health of individuals, communities, and societies. The frequency and intensity of disasters are increasing; 3–4fold compared to the last century, with 400–500 significant disasters/year, affecting >1.5 billion people worldwide and costing 250–400 billion dollars/year. Most natural disasters are directly or indirectly linked to climate change, itself a natural disaster of human origin. Armed conflict is another human self-infliction; 59 state-based conflicts are currently active, the highest since WW2 (Uppsala Conflict Data Program-UCDP¹).

The mental health impact of disasters is multifaceted, influencing both immediate and long-term mental health outcomes. Acute stress, anxiety, depression, and post-traumatic stress disorder (PTSD) represent just the direct impact of disasters on mental health. Forced displacement, economic hardship, and societal matrix disturbance can predispose survivors – especially the most vulnerable – to longer-term and indirect mental health morbidity. In some cases, there may be persistent, even transgenerational morbidity.^{2,3}

Disasters also have important systemic effects, especially in less well-developed systems, where disasters cause acute-on-chronic failures. The ethical handicap is that pressured systems fail exactly where the most vulnerable need them intact. Indeed, in disasters, mental health services are likely to fail early.^{2–4}

Disaster Psychiatry is a branch dedicated to preventing, preparing for, and responding to the mental health consequences of disasters. It relies on a range of evidence-based interventions designed to address the acute response to disasters, but more importantly, to address future disasters by prevention and preparedness.

Acute disaster response refers to supporting individuals and the wider system at times of crisis. It is well covered by guidelines by the WHO/IASC, the Sphere, RCPsych, APA, and the World Psychiatric Association, Section on Disaster Psychiatry.⁵ Beyond practical support and good clinical care, several well-supported interventions deal with the clinical sequelae of disasters. A key intervention is Psychological First Aid (PFA), which focuses on providing immediate and practical support to individuals following a disaster. Among others, effective therapeutic interventions include Eye Movement Desensitization and Reprocessing (EMDR), Cognitive-behavioral therapy (CBT), which has emerged as a gold standard for treating PTSD in meta-research, and Exposure Therapy (ET) which has lately been enhanced by XR and AI integration.

To minimize the escalation of disaster-related psychopathology, early intervention, social support, and good access to mental health services are critical. Supporting the wider system before, during, and after disasters includes psychoeducation and support for front-line responders, advising decision-makers, facilitating coordination and effective communication between services and up and down the chain of command, as well as assuming leadership when necessary.

While acute response is important, the most effective strategies for disaster psychiatry are prevention and preparedness. Disaster prevention has a broad scope involving measures that heavily rely on foresight and require multifaceted, often political, interventions. Disaster preparedness, on the other hand, focuses on enhancing individual and systemic resilience before an impending disaster. For communities, key interventions include precision screening to inform targeted prevention, community-based mental health promotion, and community-based preparedness training programs in stress management and coping skills, among others. Government and healthcare organizations also play a pivotal role in disaster preparedness; establishing effective and well-trained mental health response teams, training frontline non-mental healthcare professionals in disaster psychiatry, and ensuring that mental health services are integrated into formal disaster response plans can dramatically help. Disaster preparedness effectively constitutes secondary and tertiary preventive measures against potential psychiatric morbidity. Additionally, fostering global collaboration in research and policy development is essential. The World Health Organization (WHO) has set a global target of 80% of countries to have a system for mental health and psychosocial preparedness for disasters by 2030⁶ and the Inter-Agency Standing Committee (IASC) has called for increased

attention to mental health in disaster planning, emphasizing the need for an evidence-based, coordinated, and pro-implementation approach to disaster psychiatry.⁷

With major impending disasters like climate change, Disaster Psychiatry is posing a pertinent question: What is a psychiatrist's role in disasters? All doctors are trained to care for individual patients; therefore, responding to the clinical aftermath of disasters is familiar territory. However, disaster prevention and preparedness require a collective approach, promoting health across the wider society, as well as using selective and indicated prevention strategies, where appropriate. Furthermore, they require psychiatrists to inform decision-makers and advocate for disaster prevention measures that lie beyond the strict remit of mental health. This broader role of political advocacy constitutes a significant, but perhaps necessary, paradigm shift for the role of psychiatrists and an existential question for psychiatry.

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