

Mental health in the Syrian crisis: beyond immediate relief

According to the UN High Commissioner for Refugees, the number of registered Syrian refugees in neighbouring countries has surpassed 4 million, and more than 8 million people are internally displaced in Syria.

In this conflict, efforts and mental health research thus far have either focused on post-traumatic stress disorder (PTSD) spectrum illnesses or psychosocial support. This focus on PTSD and interventions to address immediate traumatic reactions means that efforts towards recovery and resilience, and prevention of long-term manifestations of trauma, do not exist. Such long-term and transgenerational manifestations can include severe and complex traumas, and exacerbations of pre-existing mental disorders, such as mood and anxiety disorders, psychoses, and substance use.¹

An International Medical Corps report² from clinics treating Syrian refugees reported high numbers of psychotic illnesses and non-PTSD presentations. Souaiby Lama and colleagues³ compared rates of admissions of Syrians into Lebanese psychiatric hospitals before and after the war, and reported that hospital admissions for psychosis and suicide had substantially increased after the beginning of the war. Our own experience (HJ-B and AB-O) with the Syrian Telemental Health Network, which provides health consultations to health-care providers inside and outside Syria, gave similar trends. Two-thirds of all cases fit the severe emotional disturbance (including depression and anxiety) category, with most experiencing onsets before, and exacerbations during, the war.

Most individuals exposed to trauma recover within the first year of exposure if safety and stability

conditions are established. Steel and colleagues⁴ reported that trauma-related mental illness reduced steadily over time among resettled refugees, with the exception of people with a high degree of exposure to trauma, who had long-term psychiatric morbidity.

Although efforts are understandably focused on training of staff and community members to recognise acute mental health symptoms, use psychological first aid, and establish referral systems into specialist care, the specialty needs to expand to include community-based and culturally sensitive programmes that enhance functionality and coping strategies of affected populations and protect future generations.

Long-term programmes should target pre-existing mental health issues, vulnerabilities to war-related experiences, and, most importantly, resiliency factors and functional capacity. After establishing what people need in community-oriented and collaborative ways, efforts should support individuals to restore relationships, build new, healthy patterns of interaction, and develop coping strategies. Creativity-based group programmes using the arts, such as theatre, singing, drawing, or writing poetry, might play a part, and centres designed to attract people with social events, workshops, groups, and other recovery-oriented activities can be used. An example is *Antigone of Syria*, a Lebanon-based theatre project, in which Syrian refugee women take part in workshops and produce a play, with objectives of empowerment, and support of their healing process by rebuilding communication and interpersonal skills.

Recovery-oriented programmes could provide community and family-focused psychosocial interventions (vocational, counselling, supportive trauma-focused help, etc) in addition to culturally sensitive psychoeducation. This education

would aim to increase understanding of symptoms and treatability of trauma effects and complicated grief, and reduce stigma. Such an approach is especially important because it supports the objectives of the WHO Mental Health Action Plan 2013–2030 in creation of “comprehensive, integrated and responsive mental health and social care services in community-based settings”.⁵

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- 1 De Zulueta F. From pain to violence: the traumatic roots of destructiveness. London: John Wiley & Sons, 2006.
- 2 IMC. Ongoing war creates invisible mental health crisis for Syrian people. International Medical Corps, March 16, 2015. https://internationalmedicalcorps.org/press-release/2015_03_16-syria-mental-health-report-release (accessed July 13, 2015).
- 3 Lama S, François K, Marwan Z, Sami R. Impact of the Syrian crisis on the hospitalization of Syrians in a psychiatric setting. *Community Ment Health J* 2015; published online May 16. DOI:10.1007/s10597-015-9891-3.
- 4 Steel Z, Silove D, Phan T, Bauman A. Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: a population-based study. *Lancet* 2002; **360**: 1056–62.
- 5 WHO. Mental health atlas 2014. World Health Organization, 2015. http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf?ua=1&ua=12015 (accessed Sept 6, 2015).



For the UN High Commissioner for Refugees data see <http://data.unhcr.org/syrianrefugees/syria.php>

For more on *Antigone of Syria* see <http://www.apertaproductions.org>

For more on the Syrian Telemental Health Network see <http://www.stmh.net>

Medical leadership— from inspiration to education

In his *Offline*, Richard Horton (July 11, p 120)¹ draws attention to the unmet need for leadership acumen within the medical profession. He attributes the challenge to a tendency to focus on fixing leadership weaknesses

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rather than developing strengths. Playing to an individual's strengths, he contends, is more likely to result in inspirational leadership. And while Horton rightly argues that accentuating one's strengths is a good strategy, he stops short of advocating for widely cited competency models now used to design curricula in health leadership.

In 2014, an influential European Union health policy event—the European Health Forum Gastein—ended with a call for the “development of the right sort of leadership” in health care.² Indeed, everybody can be a leader, if the right competencies are developed. But how?

The change should start with education.³ Whereas some authors call for talent identification,⁴ Czabanowska and colleagues⁵ propose a competency-based approach. Various models exist and share similar categories into which skills, abilities, and knowledge are grouped. Systems thinking, political leadership, organisational learning, communication, and emotional intelligence are among the domains.

Application of problem-based learning at all levels of professional development programmes reinforces how leadership development works best from an experiential perspective.

Are we satisfied with the present placement of health in the policy environment? Probably not. The future of medical leadership—with implications not only for individual care, but also for population health—depends on our ability to effectively produce our future health leaders.

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- 1 Horton R. Offline: Medical leadership—from inspection to inspiration. *Lancet* 2015; **386**: 120.
- 2 European Health Forum Gastein. http://www.ehfg.org/fileadmin/ehfg/Programm/2014/EHFG_Gastein_Health_Outcomes_2014.pdf (accessed July 22, 2015).
- 3 Frenk J, Chen L, Bhutta ZA, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet* 2010; **376**: 1923–58.
- 4 Day M, Shickle D, Smith K, et al. Training public health superheroes: five talents for public health leadership. *J Public Health* 2014; **36**: 4.
- 5 Czabanowska K, Smith T, Könings KD, et al. In search for a public health leadership competency framework to support leadership curriculum—a consensus study. *Euro J Public Health* 2013; **24**: 5.

Medical leadership—we need more good followers

In view of Richard Horton's Offline,¹ we would like to highlight the importance of followership:^{2,3} a concept little appreciated and understood in medicine. Arguably, until the art of good followership has been mastered, truly great and inspirational leadership cannot be achieved. This is especially true in health care, in which team working is crucial to improve outcomes.⁴ The greatest successes, for patients, are team successes.

Medical undergraduates and doctors in training are taught to

stand out, not to follow effectively. Although the focus and drive that this training fosters is very valuable, it promotes individualism rather than collectivism, and competition not collaboration.⁵ Because the profession rewards personal success and individual achievement, the most devastating health service failings result from ineffective team working and communication.

When success is measured in this way, to stand back or to accept a less visible role in a large multidisciplinary effort is counter-cultural. Many of the points made about leadership are well made and supported by evidence: leadership can be learned and is about building on strengths and inspiring and motivating others. However, although a good leader knows when to step up and make difficult decisions, a great leader is an exemplary follower who has taken the reins and is ready to pass them on when best interests demand it. Reframing medical leadership to include positive ideas of followership can only help effective team working and enable others to grow, to follow, and to lead appropriately.

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- 1 Horton R. Offline: Medical leadership—from inspection to inspiration. *Lancet* 2015; **386**: 120.
- 2 Mannion H, McKimm J, O'Sullivan H. Followership, clinical leadership and social identity. *Br J Hosp Med* 2015; **76**: 270–74.
- 3 Uhl-Bien M, Riggio RE, Lowe KB, Carsten MK. Followership theory: a review and research agenda. *Leadersh Q* 2014; **25**: 83–104.
- 4 WHO. Framework for Action on Interprofessional Education and Collaborative Practice. Geneva: World Health Organization, 2010.
- 5 West M, Eckert R, Steward K, Pasmore B. Developing collective leadership for health care. London: The Centre for Creative Leadership and The King's Fund, 2014. <http://www.kingsfund.org.uk/publications/developing-collective-leadership-health-care> (accessed Aug 17, 2015).