

Several studies have reported the frequency of mental disorders in the war-affected populations of East Africa, the most common ones being PTSD, depression, anxiety, somatisation disorder, and alcohol and substance use disorders (Neuner *et al*, 2004; Njenga *et al*, 2006); the reported prevalence of PTSD has ranged between 28% and 80.2% of the study populations. The World Health Organization (2001) estimated that, in the context of armed conflict, 10% of the people who experience traumatic events will have serious mental health problems and another 10% will develop behaviour that will hinder their ability to function effectively, and thus be unable to contribute significantly to the economic growth of that population. The most common conditions are similar to those reported above.

Northern Uganda, which has seen war for the past two decades, and which has nearly 50% of its population on the move or categorised as IDPs, has one of the world's highest rates of mental illness. In a study in two northern Uganda districts, more than 54% of the adults screened had PTSD (Njenga *et al*, 2006). Furthermore, the physical and mental health problems of the survivors of the genocide in Rwanda have been well documented. In a community-based study examining 2091 people, 24.8% met the DSM-IV symptom criteria for PTSD (Srinivasa & Lakshminarayana, 2006).

Conclusions

Although there is a paucity of local data on poverty and mental ill-health, there is sufficient evidence of a significant association between the two. It is therefore imperative

that mental health is given as much weight as any other development issue, so that appropriate programmes can be designed to address the socio-economic challenges resulting from or causing mental disorders. Furthermore, it will be only through a greater understanding of the causes of conflicts that coherent and effective strategies for dealing with the resulting mental health consequences, discussed above, can be developed.

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THEMATIC PAPERS – MENTAL HEALTH AND POVERTY

Inequity and poverty: everyday emotional disturbances and mental disorders in the Mexican urban population

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Recent decades have seen renewed interest in the study of poverty and its repercussions on various health problems, including mental disorder (Patel, 2007). There are various ways of measuring poverty; some approaches define it in economic terms, whereby health is included only as an asset that must be given to those defined as poor (Damián & Boltvinik, 2003). Other conceptions propose definitions based on the capacity of the poor to improve their standard of living, and consider health and education as essential elements in this process. This is the case of the Human Development Index (HDI), which, in addition to the economic dimension, measures other social indicators such as life expectancy, literacy and school enrolment and drop-out rates, among others (United Nations

Development Programme, 2000). On the basis of the HDI, Mexico ranks 52 out of 177 countries. According to its percentage of gross domestic product invested in health, it is regarded as a country with a medium/high income level.

Despite these data, inequity continues to be one of the main problems in Mexico, and indeed in Latin America more widely. The region's population is polarised socio-economically, and access to opportunities is markedly different for the various social sectors. According to the Economic Commission for Latin America (ECLA, 2008), the region has an extremely unequal income distribution, with the richest 10% of individuals earning 40–47% of total income in most Latin American societies, and the poorest 20% earning just 2–4%.

Poverty and inequity levels exert a direct influence on the population's health. In this respect, Frenk *et al* (1999) suggest that the poorest families, who do not have social security (health insurance given by the state), use a larger proportion of their income to pay for services, 5.2%, compared with just 2.8% for the richest sector of the population.

This paper seeks to analyse the impact poverty and inequity have on the mental health of the Mexican population. The information analysed is drawn from three studies undertaken on the urban population inhabiting Mexico: the National Survey on Psychiatric Epidemiology (Medina-Mora *et al*, 2003) and two studies carried out on different communities in Mexico City (Berenzon & Mora-Ríos, 2005).

Factors that produce stress and emotional disorders

The constant economic and social crises that Mexico tends to experience mean that the main sources of concern in people's everyday lives are related to financial problems (when they do not have enough money to cover their basic needs and debts, and it is difficult to find or keep a steady job); 'suffering' is a term commonly used to describe this sort of worry.

Poverty has particularly affected men. For example, unemployment affects them especially, not only because of the economic problems it causes but also because it undercuts their social validation in their role as providers, which is their main source of self-esteem. Unemployment is widely perceived as equivalent to failure.

For women, poverty tends to be linked to their biological condition (e.g. nutritional shortages, frequent pregnancies, inadequate care), coupled with excessive responsibilities (both inside and outside the home) and the social role that has been assigned to them.

Factors in the environment, such as violence and lack of safety on the streets, are also major sources of concern to those with scant financial resources; for example, robbery, assaults and other forms of crime predominantly occur in the communities where they live. Other sources of concern include intra-familial conflict and violence.

Emotional distress is extremely common among this population and can be seen as a natural reaction to the stressful social circumstances these people face, derived from living in a context of inequity and poverty. In many cases, it would be inappropriate to give such individuals a clinical diagnosis. However, it is not easy to decide where to draw the distinction between a genuine psychiatric disorder (depression and anxiety) and normal responses – emotional distress – to stressful social conditions. A diagnosis based on the assumption that symptoms alone indicate the presence of psychiatric disorder overestimates prevalence. The only way of distinguishing normal suffering or distress from a true disorder is to take into account the context in which symptoms emerge (Horwitz & Wakefield, 2007).

Poverty and mental disorders

Inequity and poverty increase the risk of psychiatric disorder. Data from transnational surveys undertaken in Brazil, Chile, India and Zimbabwe show that the rate of the most common

mental disorders is approximately twice as high among the poor as among the rich. Similar results have been observed in the United States, Latin America and Europe.

The results from our studies show that, regardless of the type of distress involved, interviewees with a family income of less than one 'minimum salary' displayed higher prevalence rates (Berenzon & Mora-Ríos, 2005). The evolution of disorders is also heavily influenced by the individual's socio-economic status. Our data show that among people of low socio-economic status (SES), only one out of every five persons with an affective disorder receives care, while only one out of every ten with an anxiety disorder is treated. Affective disorder was the diagnosis that elicited the greatest use of specialised services, followed by anxiety and substance misuse. The length of time patients of low SES take to seek care varies between 4 and 20 years, depending on the type of disorder (Medina-Mora *et al*, 2003). This low service use is more common among the uninsured population with limited resources, for whom purchasing medicine entails exorbitant expense.

In addition to the shortage of mental health services, there is a lack of information about these services. Moreover, the population fails to seek available help because of the discrepancy between their felt needs and the type of assistance offered by public health services. While the population has a definition of the need for care based on its everyday problems, which constitute major sources of distress, public health services offer care based on psychiatric diagnoses. The lack of fit between the population's felt needs and the care available also hinders people's access to treatment (Berenzon *et al*, 2006).

How do people cope with their problems?

In localities with scant financial resources, self-care strategies are commonly used, ranging from the use of herbs and diets to self-control behaviour strategies to eliminate the disorder, such as will-power or 'gritting your teeth' until the problem goes away on its own. People also often take part in religious rituals associated with a strong belief in God's healing power. Another important source of help is the social network, which can provide, in addition to advice, financial resources and/or other types of support, such as child care. Still other forms of support include faith healers, alternative therapists and general practitioners. People usually resort to mental health specialists such as psychologists or psychiatrists only when the problem persists and is regarded as unmanageable. The type of strategy adopted is influenced by: social and cultural factors; political and economic restrictions; the available treatments and interventions; and the characteristics of the problem and the perception of its severity (Berenzon & Mora-Ríos, 2005).

Unlike what happens with other disorders, for which the population is able to identify the affected organ (such as the heart) and therefore the specialist who should deal with it (such as a cardiologist), people with mental afflictions fail to identify their problem and to realise that they need to see a psychiatrist. These and other factors mentioned earlier keep patients away from services, increasing costs for the health system and unnecessarily prolonging the suffering of the people affected and their families. There is therefore a need

to offer services based on the population's felt needs and to implement actions based on informing the population about mental disorders, their expression and treatment.

Discussion

That part of the Mexican population living in inequity and poverty experience many stressful situations, such as instability, lack of safety, violence, desolation and family problems, resulting in frequent emotional distress. It is important to distinguish between this emotional distress as a natural response to adverse situations (and to treat it as such) and 'psychiatric disorder'. On the other hand, poverty also increases the risk of the occurrence of mental disorders, which need proper detection and treatment to reduce the burden they place on this population.

The main questions arising are:

- where to draw the line between distress and disorder
- how to deal with emotional distress without pathologising suffering yet preventing the risk of mental disorders from increasing
- how to increase awareness among mental health professionals regarding the population's distress, concerns and needs, which are not always described in psychiatric manuals
- how to sensitise and educate people of low SES about mental disorders to reduce the period of latency between the onset of the disorder and their seeking care.

Achieving better mental health coverage entails both increasing the supply of services, especially in primary care, and adapting them to the population's needs, which are clearly linked to social and economic inequities, gender discrimination, violence and other health conditions. In this respect, as Desjarlais *et al* (1995) suggest, 'the link between the social

context and public health is a social event and should be acknowledged as such'. Thus, no mental health strategy can be proposed outside a state policy that guarantees minimum conditions of well-being for vulnerable groups in relation to the satisfaction of basic needs, such as food, housing and the right to education and health.

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COUNTRY PROFILE

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Psychiatry in Kuwait

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This paper describes the historical background, development and current status of psychiatric services in Kuwait. In addition, present practices and the outlook for further development of services are outlined.

Kuwait is a rich oil-producing country with a gross domestic product (GDP) of US\$74.6 billion and an area of 17820 km². The mid-year population of Kuwait in 2007 was 3399637, of whom 30.75% were Kuwaitis, while expatriates, mainly from the Indian subcontinent (39%) and other Arabs (22%), made up the rest (Public Authority for Civil Information, 2007).

The Ministry of Health (MOH) has, over the years, been the principal care provider in the country. Although a number of

private hospitals (albeit regulated by the MOH) have taken up some of the load, delivery of psychiatric services is limited to the MOH hospitals. The health services are provided through five general hospitals (one for each health region), nine specialised hospitals, 78 primary healthcare clinics and 38 diabetes clinics, distributed uniformly across the country (Ministry of Health, 2006).

Prevalent beliefs and practices

Like all Arab communities, Kuwaitis believe in spiritual (*jinni*) possession, the 'evil eye' and sorcery; these are not