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## **Psychiatrist or psychosocial adviser? Confusion, controversy and progress in mental health**

*A psychiatrist at a recent coordination meeting in Sri Lanka **chose** to present himself as a 'psychosocial advisor' — despite being a psychiatrist. Psychologist Jane Gilbert asks how has this come about? And what does this change of identity say about mental health in the humanitarian sector?*

It was only in the late 1980s that mental health and terms such as 'trauma' and 'psychosocial' began being mentioned in humanitarian-aid work. The emotional suffering wrought by the tsunami has brought mental health issues to the fore, but, while there is progress, there is still much confusion and controversy.

As with any intervention, how can we be sure we do no harm? Mental-health services in the UK are still bedevilled by controversy and disagreement amongst professionals. What can we offer the tens of thousands of people affected by complex emergencies whose language and culture are very different, and whose life circumstances are beyond anything most of us have experienced?

Table 1 opposite summarises some of the current and recent major issues in mental health in humanitarian emergencies confronting the sector

**Table 1. Current and recent mental-health issues confronting the humanitarian sector**

<b><i>Confusion</i></b>	<b><i>Controversy</i></b>	<b><i>Progress</i></b>
Words with a specialist meaning in mental health are now common parlance. 'Trauma' — meaning a host of things — is used by journalists and the public. Newer words such as 'psychosocial', and 'social well-being' are not clearly defined.	Is the concept of 'post traumatic stress disorder' useful when whole populations have been subject to catastrophic events? Is it a way of transferring responsibility to Western professionals? <sup>1</sup> This question continues to generate powerful controversy.	NGOs now discuss mental-health issues far more openly, and lessons are gradually being learned. It is increasingly recognised, though not fully accepted, that psychological wellbeing needs to be integrated within all programmes.
The distinction between mental illness and the <b>normal and expected</b> emotional distress following catastrophic events is often blurred.	Should mental health and psychosocial issues be addressed if basic needs for food, shelter and safety have not been met?	Many NGOs now undertake mental health and psychosocial programmes: some of the plethora following the tsunami have seemed to impose Western models, others have been truly psychosocial and thoughtful, supporting the restoration of community

		life and recognising the crucial role of local religious beliefs in the process of healing. <sup>2</sup>
Assessing and measuring the impact of mental health/ psychosocial programmes is difficult. Donors prefer quantitative data, but how can this catch the 'invisible changes' of emotional healing which enables someone to begin to return to the ordinary — the washing, mending the roof.	Do assessment tools, methods and treatments developed in the West have any relevance? <sup>4</sup>	Since 2004 the <i>Sphere Handbook</i> has included 'Mental health' In recent publications WHO <sup>3</sup> : <ul style="list-style-type: none"> <li>- emphasises the normality of acute emotional distress within populations exposed to extreme stress</li> <li>- questions the useful application of PTSD to large populations</li> <li>- advocates a psychosocial approach to mental health — the rebuilding of communities and social structures, and the role of religion and traditional rituals within this process.</li> </ul>
Emotions are a universal part of being human, but how emotional distress is expressed and understood differs between cultures.	Should agencies offer counselling —alien and potentially stigmatising — that might destabilise and undermine local healing and community resources? <sup>4, 5</sup>	It is now being recognised that minds and bodies are not separate and that a holistic approach is needed. Fundamental issues of culture and language, and communities' normal emotional reactions to distress are being better understood.  It is acknowledged that aid workers are psychologically at risk — and that training in psychological self-care should be part of all pre-departure training. <sup>6</sup>

### **The person in context — psychosocial approaches**

Overall, since the 1990s there has been a significant move away from medical/psychiatric to 'psychosocial' programmes.

What does 'psychosocial' mean? Agencies are placing advertisements for 'psychosocial project managers' and 'psychosocial advisers' — with sometimes very different roles and responsibilities. *The Oxford English Dictionary* defines 'psychosocial' as 'pertaining to the influence of social factors on an individual's mind and behaviour'; while Sphere Standard 3 says 'social interventions have secondary psychological effects and psychological interventions have secondary social effects'.

Sphere clearly states the rationale for psychosocial programmes — that positive changes in social frameworks affect psychological wellbeing. At one level this is completely 'obvious', but it can be forgotten. After basic physical needs, all people need families, employment, social networks, means of making sense of what has happened to them and reasons for living — the essence of psychosocial programmes.

## **Additional perspectives**

### **Loss**

The massive dislocation of peoples through war, famine or other catastrophes involves not only deeply distressing events, but the destruction of people's social and physical world — catastrophic loss. Emotional responses to loss are universal — fear, anger, and grief. The notion of **cultural bereavement** can be helpful in understanding emotional responses and what could be done to help. People may have lost those whom they loved, their homeland, their status, the social and cultural patterns of their society and also, more importantly, life itself may no longer have meaning.

The normal human response to loss is to grieve, to try and make sense of what has happened and begin to re-build and adapt to the changed circumstances. No matter how terrible the events, people are not helpless victims, without resources and resilience. Rituals and the gradual restoration of normality in everyday life can create and revive attachments which have been lost, help a community re-form, and help restore meaning to life. In Cambodia, huge differences in emotional recovery were found in camps where Buddhist monks were actively identified and supported to carry out rituals, particularly in relation to the dead.<sup>5</sup> The role of religion and local healers has also been extremely significant in the aftermath of the tsunami, including rituals that have taken place even when bodies have not been found.<sup>2</sup>

### **Another way of looking at 'trauma'”<sup>5</sup>**

Suffering can be defined in many different ways — as heroic, the will of God, justifiable because of a higher cause, or traumatic — depending on who is doing the defining. So-called 'traumatic' events can also continue for a long time.

Most humanitarian emergencies are not completely unanticipated physical catastrophes like the tsunami, and people more likely to have been through a number of stages:

- Anticipation that something awful is going to happen and having to make decisions about staying or leaving, for example. Some decisions may be deeply regretted later.
- The experience of a terrible event, such as violence and death of loved ones, or an ongoing event such as gradual starvation or migration.
- Survival, and possibly guilt, at being safe, but waiting for one's fate to be determined by others — feelings of disempowerment, helplessness, and disorientation.
- Gradual adjustment to a new place/new life.

What meanings do people attach to these different stages? How do those caught up in humanitarian emergencies define and make sense of their experience?

### **Future priorities**

The following list of priorities, although essentially a personal view, are being expressed by many in the field:

- Terms must be defined more clearly — with agreement on meaning. Mental illness and acute emotional distress must be clearly differentiated.
- The mentally ill and those with learning disabilities should be identified and receive specialist care, alongside community-education activities and working to reduce stigma. Support to local and existing services may have long-lasting benefits. **Both psychiatric services and psychosocial programmes are required.**
- Understand *before* you act: we need to ask and to learn how communities dealt with mental-health problems **before the emergency**. These elements can then be integrated with Western approaches.
- Whose voice? Much lip service is paid to human rights and empowerment. People need to be able to respond in their own way, and **in their own words**. Working with local healers and religious leaders is essential for strengthening local voices and capacity.
- Aid workers can be 'anthropologists'. Even when physical needs are overwhelming and must be met, it is possible to find out what is important to people in terms of emotional and social support — for example, burial ceremonies, rituals.
- Different measures of assessment and impact must continue to be developed. Connections between the restoration of social groups,

religious activities, everyday activities and psychological wellbeing are 'common sense', but emotional healing, religious belief and the restoration of meaning in life are very difficult to 'measure'.

- Good practice in psychosocial and mental-health programmes needs to be shared and disseminated more widely.
- Aid workers need more training in mental-health issues.<sup>7</sup> RedR-IHE, with its integrative approach to health, has taken a lead by incorporating a mental-health component in its short courses, but mental health needs to be part of all pre-departure and other training.

To return to our psychiatrist at the meeting in Sri Lanka. The mentally ill and those whose emotional reactions to what has happened are incapacitating, need specialist help. Facilitating the recovery of communities requires a broad psychosocial understanding and the capacity to work creatively with the communities' own resources. Both psychiatrist **and** psychosocial advisor are needed.

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