Borderlands of Mental Health. Explorations in Medical Anthropology, Psychiatric Epidemiology and Health Systems Research in Afghanistan and Burundi

P. Ventevogel

English Summary

This thesis focuses on Afghanistan and Burundi, two countries that are facing ongoing, complex humanitarian emergencies and are characterised by ethno-political collective violence. I have worked in both of these countries, with the nongovernmental organisation HealthNet TPO, setting up mental health programmes, as well as conducting research when time allowed me.

The research presented in this thesis, specifically relating to mental health in Afghanistan and Burundi, was guided by three central research questions:

1 What are local perspectives on mental health and healing by people within complex humanitarian emergencies?
2 How can mental health problems within complex humanitarian emergencies be measured?
3 How can functional systems to address mental health and psychosocial problems within complex humanitarian emergencies be developed?

Answering these central questions required the use of a variety of research techniques, drawn from diverse academic fields.

The Introduction (Chapter one) introduces the reader to these various contexts, which framed and informed the research presented here. Thereby, the chapter aims to: 1) provide an overview of global mental health, and more specifically of mental health and psychosocial wellbeing within complex humanitarian emergencies; 2) describe the socio-political background of Afghanistan and Burundi; and 3) sketch the academic disciplines utilised in this thesis: i) ethnographic research to explore local perspectives; ii) epidemiological research with the aim of measuring mental disorder in populations; and iii) health systems research within global mental health, to analyse how mental health interventions can be made functional and sustainable.

Local perspectives on mental health and healing

After introducing the complex contexts in the Introduction to frame and guide the reader, in the first part of the thesis I explore how people in Burundi and Afghanistan and conceptualise problems of mental health and wellbeing, and how they seek help for these issues.

Chapter two presents the results of a study using rapid appraisal methods, such as focus group discussions, among war affected Burundian adults. We asked Burundians, in four provinces of the country, what they saw as the main difficulties and problems resulting from the war. The respondents identified ill health, poverty and the breakdown of social fabric as major effects. Amidst these concerns, issues related to mental health and psychosocial wellbeing were also mentioned, including: depressive states, fear/anxiety, grief, madness, and substance abuse. This exercise makes it clear that mental health and psychosocial wellbeing are a serious concern to people in humanitarian emergencies. In the remainder of the chapter, I argue, therefore, that the design of mental health interventions should take into account

what is most important to the beneficiaries and relate to how they conceptualise their problems.

Chapter three delves deeper into 'local views', presenting a comparative analysis of ideas around mental illness in Burundi and three other conflict affected settings in east Africa. Participants of focus groups, in all four settings, described local syndromes that were defined by severe behavioural disturbances and that corresponded remarkably with the grand category of 'psychotic disorders' of professional psychiatry. However, ideas about aetiology and the meaning of symptoms differed considerably with professional ideas on psychosis. Additionally, those residing in each of the four communities had local terms for conditions characterised by sadness, loss and social withdrawal. Such concepts have some similarities with 'mood disorders', as defined in professional psychiatry, but it would be wrong and perhaps dangerous to reify them into 'cultural syndromes', complete with a coherent set of symptoms and aetiology. In practice, they function as *idioms of distress*; culturally prescribed ways of communicating that someone feels unwell and/or unhappy. Such idioms *could be* indicative of psychopathological states, but certainly should not be considered as *always* indicative.

Chapter four describes traditional healing in Burundi, through an analysis of the practices of seven diviner-healers (*abapfumu*). These practitioners use spiritual methods to diagnose spirit possession and to assist in dealing with someone's affliction. The *adorcistic* healing methods of the *kubandwa* cult are meant to appease spirits and assist the possessed person in regaining a place within society. However, these have (to some extent) been replaced by an *exorcistic* technique called *gucekera*, in which spirits are aggressively driven out of afflicted people. My co-authors and I hypothesise that these changes are related to the effects of modernity, compounded by the effects of war that have deeply affected the social fabric. Additionally, we connect research findings to the ethnographic literature on traditional healing and divination found in other parts of Africa.

During the period I worked in Afghanistan I had, unfortunately, very limited opportunities to conduct ethnographic research on how people conceptualise mental disorders and how they seek help. Instead, in chapter five, I present a literature review that provides a synthesis of child-focused research and intervention literature from various disciplines pertinent to mental health and psychosocial wellbeing in Afghanistan. This review, containing references to both ethnographic and epidemiological literature, makes clear that the myriad of mental health and psychosocial problems found in the Afghan population encompass a wide array of problems that go far further than strictly 'war related' pathology, but also, and perhaps foremost, include problems related to poverty, inequality, and other forms of structural adversity. It was also clear that for Afghans, cultural concepts such as 'honour', 'family unity' and 'hope' play a significant role in building resilience to adversity. However, cultural values do not only function as an 'asset', but generated within specific contexts, they can also function as a straightjacket, thwarting individual aspirations and freedom.

Measuring mental health

In the second part of this thesis I explore issues around the measurement of mental health issues. My main concern here was how the results of standardised, brief, self report instruments should be interpreted.

Chapter six is the report of a cross-sectional, multi-cluster sample survey among 1011 randomly selected adults in the eastern province of Nangarhar in Afghanistan. The survey was conducted a year after the fall of the Taliban. One of the main features of this study is the estimation of prevalence rates of symptoms of common mental disorders in this early post conflict setting. High symptom rates were reported for depression (38.5%), anxiety, (51.8%), and PTSD (20.4%), with a marked gender difference: odds ratios for women compared to men were 7.3, 12.8, and 5.8 respectively.

Chapter seven examines the validity of the Hopkins Symptom Checklist-25, one of the instruments utilised in the study described in chapter six. This work was prompted by concerns over the use of such instruments within the context of complex emergencies in general, and in Afghanistan in particular. Together with my co-authors, I tested the HSCL-25 and another often used brief self report scale for mental disorders, the Self-Reporting Questionnaire-20. These two self report scales were compared against a 'gold standard' semi structured psychiatric interview. The results were sobering; both short screening instruments had modest properties to correctly identify mental disorders (area under the curve was 0.73 and 0.72, respectively). Optimal cut off points of the scale differed for men and for women. The study results shed new light on the results of earlier studies in Afghanistan with the HSCL-25 as it is likely that these studies overestimated the prevalence of mental disorders among women, while at the same time, underestimated the prevalence in men.

Chapter eight also explores the psychometric properties of self report scales for mental disorders, but in this instance with a focus on children in Burundi. It explores the psychometric properties of the Depression Self-Rating Scale (DSRS), the Child PSTD Symptom Scale (CPSS) and the Screen for Child Anxiety Related Emotional Disorders (SCARED-41), in a sample of 65 primary school children in Burundi. The external 'gold standard' criterion was a comprehensive, semi structured, clinical psychiatric interview for children, according to the DSM-IV criteria (the Schedule for Affective Disorders and Schizophrenia for School-Age Children – K-SADS-PL). The DSRS and CPSS scales had acceptable properties for detecting depressive disorder and posttraumatic stress disorder (area under the curve was 0.85 and 0.78, respectively) if cut-off points were put considerably higher than in western, norm populations. The results, utilising the SCARED-41 to identify anxiety disorders, were less encouraging (AUC: 0.69). The relatively weak performance of the SCARED-41 could be attributed to the fact that it covers various categories of anxiety disorders, with perhaps limited cultural/construct validity.

Making systems work

A third focus of this thesis is how to deliver mental health interventions in ways that 'make sense' within the context, and particularly how to make such interventions

sustainable. To some extent, almost paradoxically, post conflict settings provide policy opportunities for the development of better mental health care. This is due to a shared sense of urgency, by many stakeholders, on the need to address the consequent, painfully visible, mental health issues.

Chapter nine is a description and critical analysis of the programme for mental health and psychosocial support by HealthNet TPO in Afghanistan. The programme, which I helped to set up during my period of work in Afghanistan (2002-2005) aimed to include essential mental health aspects in the general health care system, through training of staff at all levels of the health system in identification and management of priority mental health conditions. The chapter follows the developments in six rural districts (the '*Shinwar cluster*') in Nangarhar over a ten-year period (2002-2011). The number of patients with mental disorders that were treated within the general health services increased tremendously, but the downside was that, inadvertently, the programme may have contributed to a process of medicalisation of social problems.

Chapter ten similarly describes and analyses a mental health and psychosocial support programme in Burundi. Within a time frame of eight years, the context had changed from active war to a fragile post conflict setting. During this period, the programme activities shifted from the delivery of direct services to capacity building activities aimed at embedding psychiatric services and psychosocial assistance within existing local health services and social systems. In the years 2005-2008, I lived in Burundi and was part of that transformation process, in which we faced formidable challenges and full sustainability of mental health and psychosocial activities was not realised.

Chapter eleven synthesises the literature around the integration of mental health into non-specialised (e.g. primary) health care. The paper was written with special attention to an undesired side effect of such integration: namely the medicalisation of distress when using a narrow biomedical approach. During my work in Afghanistan, Burundi and later in various other complex humanitarian emergences, I became increasingly convinced that the integration of mental health into primary healthcare should be accompanied by strengthening other levels of health care and by fostering community support.

Reflections

The last chapter of this thesis reflects on implications of my work for the development of global mental health research and practice within complex humanitarian emergencies.

A first implication is that culture and context must be taken seriously. The cases of Afghanistan and Burundi illustrate that collective violence and war related adversity have an impact on various levels. The individual focus of classical psychiatry and clinical psychology may obscure the effects of violence on a collective level; social relations are weakened, people in communities do no trust each other anymore, ways to help each other have become redundant or dysfunctional. For practitioners and policy makers alike it is important to gain an understanding of local cultural

categories of mental illness and distress. Such cultural categories, even if they may seem closely aligned to mainstream psychiatric categories, should not be seen as synonyms for professional psychiatric categories. Such local terms are pragmatically used, grounded in particular contexts that are embedded into local webs of signification.

A second implication is that psychiatric epidemiology in complex humanitarian settings should move away from its gaze on collecting prevalence figures, and instead reconceptualise mental health and psychosocial wellbeing as states that are culturally embedded and influenced by social factors. A key challenge is to ensure that epidemiological research does not conflate social suffering with mental disorder.

A third implication is that mental health programming in complex humanitarian settings requires a sustained attempt to use systems approaches. The projects in Afghanistan and Burundi were quite different for each other, but some lessons learned were similar, particularly that installing basic mental health within general care should be connected to community based activities, and be firmly rooted in a general health-system-strengthening approach. Integrating mental health care into primary care carries the inherent danger of promoting biological and psychological interventions for problems that also have major social drivers. I have come to believe that mental health care, as part of the formal health care system, must be accompanied by community based psychosocial interventions that do not emphasise the 'toolkit of the medical professions', but rather utilise the mobilisation of available community resources and the strengthening of resilience and coping.