



Trauma-focused mental health interventions

Anthropology is vital in bridging the gap between Western approaches to mental health and psychosocial support (MHPSS) and local realities, improving both the outcomes and the accountability of such programmes.

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Recommendations

1. Practitioners and policy makers in the field of MHPSS need to work towards a **more thorough and consistent implementation of Inter-Agency Standing Committee (IASC) Guidelines** for MHPSS (2007), specifically to reduce a focus on trauma and post-traumatic stress disorder (PTSD) in emergencies, rather building and relying on local and culturally appropriate initiatives.
2. The field of MHPSS needs to **account for the wider socio-economic consequences** of the introduction of new mental health discourses and practices, specifically in situations where:
 - a. Money (or other goods with economic worth) are exchanged for participation in randomised controlled trials (RCTs) that test new therapeutic approaches.
 - b. Where imported approaches contribute to wider trauma or victim discourses in local contexts and may create currencies of suffering that not all individuals can access, thus creating new forms of marginalization.
3. To enable both the building of locally and culturally appropriate initiatives (Recommendation 1) and a better understanding of socio-economic consequences of introducing new mental health narratives in non-Western settings (Recommendation 2), practitioners and policy makers in field of **MHPSS need to involve anthropologists and mental health specialists with local knowledge**, in the design, implementation and evaluation phases of mental health interventions.

Background

Since the 1990s, humanitarian programmes focussing on poor mental health related to emergencies, and particularly armed conflict and violence, have been growing, representing a new branch of aid referred to as “Mental Health and Psychosocial Support” (MHPSS) interventions. Northern Uganda suffered for more than twenty years (1986–2006) under a bloody civil war between president Yoweri Museveni and the rebel group Lord’s Resistance Army (LRA), who abducted more than 30,000 people. A common narrative describes the Acholi population as collectively “traumatized”, with trauma-focused programmes flourishing in the region; interventions range from various forms of counselling, to specific psychological therapies including Narrative Exposure Therapy (NET) and Cognitive-Behavioural Therapy (CBT).

Interventions are often delivered by local mental health workers previously trained by expatriate clinicians. The Inter-Agency Standing Committee (IASC) Guidelines for MHPSS (2007) actively discourage a narrow focus on trauma and PTSD, also stating the importance of building on local and culturally appropriate initiatives. While such guidelines were met with enthusiasm, this guidance had not been taken on board everywhere.



Methods

Fieldwork in northern Uganda between 2015 and 2018 involved participant observation and qualitative in-depth interviews with local mental health workers, Ugandan mental health specialists and international specialists working in MHPSS interventions that included elements of trauma-focused therapies, in addition to former LRA abductees who received trauma-focused psychological therapy on their return home. Fieldwork was conducted under the Trajectories of Displacement grant hosted at Firoz Lalji Centre for Africa at the London School of Economics and Political Science, where formal ethical approval was obtained.

Findings

- 1) ***Mental health workers with local knowledge re-shape Western therapies.*** Trauma-focused psychological therapies designed in the Global North often lack cultural sensitivity to the local context and are, therefore, actively re-interpreted by mental health specialists on the ground, who re-shape such therapies to more locally appropriate interventions.

In northern Uganda, local practitioners often replace the focus on the client's account of an allegedly traumatic event with practices closer to forms of "traditional counselling". This consists of a unilateral flow of moral guidance, central in regulating Acholi social life, which draws on the practice of "advice-giving" often provided both by ritual and religious leaders at meetings, and by elders in the traditional process of cultural education of youth. As ideas and values embedded in Western therapies – namely, the focus on the individual as the site of both pathological and therapeutic processes, and the emphasis placed on talk therapy – are of limited cultural relevance in Acholi, and therefore not helpful in a therapeutic setting, local counsellors choose instead to rely on existing cultural tools. This re-shaping was an informal process, not necessarily acknowledged or examined by formal evaluation processes.

Secondly, Western therapies, and the academic literature that evidences their effectiveness, are based on research trials that are often impossible to implement in low resource settings. For example, incentives provided during trials to retain participants in multiple follow up appointments cannot be replicated in ongoing practice. Hence, local specialists adapt trauma-focused therapies to account for local conditions, where patients may be able to attend far fewer appointments.

- 2) ***The introduction of Western mental health discourses has extensive consequences on the socio-economic context.*** The introduction of trauma-focused mental health interventions contributes to the narratives of trauma as a form of currency. In northern Uganda, several NGOs/charities target formerly abducted individuals, whose testimonies are central to their product. In this way, histories of trauma and victimhood are heavily marketized to justify NGOs and charities' operations. However, while some individuals can capitalise on such narratives to obtain socio-economic support, others cannot, often because their story is more nuanced, less sensational and more difficult to convey to international donors.

Many former abductees do not fit the criteria to be supported by NGOs – i.e. those that are acquiescent and adhere to social norms or those that seem confident and eager to move on with their lives. Where they do not overly embrace the idea of being traumatised (e.g. the main cause of their suffering is related to stigmatization and social isolation suffered back in the community, and less to allegedly traumatising event in their past); they remain largely invisible to NGOs, and excluded from important sources of humanitarian support. The disparity in opportunities to



capitalise on trauma narratives results therefore in the increased marginalisation of the most vulnerable individuals.

Conclusion

Anthropological analyses demonstrate that trauma-focussed MHPSS interventions are actively re-interpreted by local mental health practitioners, differing considerably from the way they are portrayed in scientific literature and academic discourses. They also highlight that MHPSS are highly influential to the wider context they are working within, with possible detrimental effects. To understand (and be accountable) for any outcome they might have – intended and unintended, clinical and social – is a key responsibility of those involved in the planning, implementation, and evaluation of MHPSS programmes. Mental health interventions in humanitarian crises need to better appreciate and adapt to specific local cultural and socio-economic contexts. To do this, local specialists should be better embraced as a valuable resource: this research demonstrates they provide a wealth of experience that is sensitive to both the cultural and socio-economic context.

References

Inter-Agency Standing Committee. (2007). *IASC guidelines on mental health and psychosocial support in emergency settings*. Geneva, Switzerland: IASC 2007. Available at:

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