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Ethical Thinking

International Mental Health Activities and Communities

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The Asian tsunami (26 December 2004) prompted humanitarian agencies to divert major resources and personnel to promote programmes in keeping with dominant Western concepts of 'mental health programmes'. The Pakistan Earthquake, Sichuan earthquake in China and Cyclone Nargis in Myanmar soon followed. This emphasis—by both international and local nongovernmental organisations (NGOs)—on Western-style counselling, psychotherapy and befriending was at the expense of programmes addressing the physical destruction wrought by natural events. However, there is a huge gap in the psychosocial interventions in conflict and disaster affected countries and ethics. Ethics in the sense of how international and national organisations could measure and monitor their "fair and honest dealings" (Kellehear 1993, p14) with the communities in which they work. Also the fact that psychosocial services and research dealing with sensitive issues such as torture, violence and bereavement requires a continual process of reflection and reassessment, demanding constant awareness to the changing situation, in order to ensure it remains ethical.

Although there are many ethical frameworks from professional bodies such as British Association for Counseling and Psychotherapy (BACP, 2004) as well as guidelines from Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007) there is no monitoring mechanism on how mental health practitioners working in different countries that are affected by conflicts and disasters. This has created a situation where anyone who has little or no knowledge on mental health goes into communities to conduct 'psychosocial' activities or programs.

This paper questions the needs of such standalone activities, the ethics of conducting such programs in communities and monitoring unethical practices in communities by international mental health experts.

Pageant of Interventions

The existing humanitarian discourse has changed towards the assumption that conflict and disaster affected communities need psychosocial and mental health assistance. According to Pupavac (2001, p.358) "trauma is displacing hunger in Western coverage of wars and disasters". Further the mental health experts from the West are arguing that disaster-affected communities, including children, often have negative outcomes - including ill health, loss of motivation, and depression. (Coddington, 1972; Vogel & Vernberg,, 1993; and Joseph, Williams & Yule, 1995)

But the question is: Were such communities seeking mental health and psychosocial assistance framed in this way? The impressions gained from field level discussions are that they were not. They did not want counseling, instead pointing to their shattered homes and livelihoods. The children were observed to be sad, and a few with nightmares, but well functioning and keen to have their schools rebuilt. (Personal observations of the author in post-tsunami Sri Lanka, 2004-2005) Surveys from the war affected northeast of Sri Lanka indicate that even people who turned up at mental health centres were actually primarily concerned with issues like jobs. (Millar, 2005, p.209) Community priorities continue to be on regaining ways of life and means of livelihood. A human rights assessment conducted by Action Aid International (January 2006) pointed out that there are still major problems in land, housing, livelihoods, discrimination of women, and inequities in reconstruction programs in tsunami-affected countries. The report notes that "a major effort is required to prevent further abuse of human rights and to correct the wrongs that characterize the first year of the tsunami response [by all parties]" (Tsunami Response: A Human Rights Assessment, Action Aid, January 2006, p. 10).

Despite community concerns and longstanding arguments by Summerfield, Hume and Toser (1991, 1992, and 2000) about the limitation of Western medical models of mental health, International agencies continue their pageant of psychosocial activities around the world.

> *"He came in to our village after the tsunami with an assistant. We were told [by the local NGO] that he is a mental health expert from the UK. They said that they are going to treat us with our mental health problems. Then this man sat down in front of my wife and started pointing a finger at her eyes. Yes, we are sad and upset about all what happen. I thought that they are going to help us to re-build our lives, but I got really mad when I saw this strange man pointing a finger at my wife. When I questioned this in an angry tone, the translator said that my anger is the mental*

health problem and I need special support. What nonsense? I asked them to leave my place immediately."

A fisherman from tsunami affected Eastern Sri Lanka (Direct Discussion with the Author), October 2005[1]

The above situation was an example that tsunami affected people were offered psychotherapeutic tools without explaining. Further discussion by the author with this fisherman explained that the western mental health expert and his assistant were trying to use EMDR (Eye Movement Desensitization and Reprocessing) Therapy for his wife. However, scholars such as Ashcroft, discuss the personal and moral qualities of the practitioner, stressing the personal dimension and the quality of the relationship in therapy. Further, Ashcroft (2001; 10) states "Counseling and psychotherapy are thoroughly ethical activities, in the deepest sense of the term 'ethical'. They are concerned with the process of discovering the good life". However, the above statement by the Sri Lankan fisherman does not tally with this ethical sense explained by Ashcroft.

"One morning a team of 'psychosocial specialists' came to our camp. We were told that they are from the US and here to help us to provide psychosocial activities. All of us gathered in the community hall and through translation they told us the importance of sharing our sadness and grief about our losses from the tsunami. Then the man and the woman who came from the US started hugging us. I felt very uncomfortable and irritated. During the tea break I went home and told my mother and she told me to keep away from them"

A teenage girl from tsunami affected Eastern Sri Lanka (Direct discussions with the author), October 2005[2]

Through that discussion it was revealed that the 'psychosocial experts' came from the US did not have a clue about boundaries of the Sri Lanka culture. Although it may be comforting to hug a person who is sad or grieving in the US, even when one is not personally acquainted with them, the Sri Lankan culture in general do not allow hugging strangers. The APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (1990) specifically mention the need for a socio-cultural framework for service providers to consider diversity of values, interactional styles, and cultural expectations in a systematic fashion. They need knowledge and skills for multicultural assessment and intervention, including abilities to:

Recognize cultural diversity;

- Understand the role that culture and ethnicity/race play in the socio-psychological and economic development of ethnic and culturally diverse populations;
- Understand that socio-economic and political factors significantly impact the psychosocial, political and economic development of ethnic and culturally diverse groups;
- Help clients to understand/maintain/resolve their own socio-cultural identification; and understand the interaction of culture, gender, and sexual orientation on behaviour and needs.

As there are many similar guidelines and ethical frameworks in the US and Europe, the practical issue is that none of these are practiced or monitored in the field. The real complication is when local practitioners receive training from Western experts and start thinking as counsellors or psychotherapists. Most of the time, they get confused between psychosocial or counselling tools that they receive in these trainings and living realities of their communities.

> *"I received two weeks training from the psychologists from the head quarters of my organisation [a European based NGO] about a year ago. This training mainly focused on how raped or torture victims can express their feelings and how counsellors like me can help them to get in touch with their feelings. This is a rewarding job and all most all the women I come in to this counselling room freely talk about their feelings and cry. But the real problem is men. They don't cry and do not like to talk about their feelings and emotions."*
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> A Sudanese Counsellor from Garsilla, Western Darfur
> (Direct Discussion with the Author), May 2005[3]

In this confusion, the above counsellor from Sudan is not alone.

> *"I became the senior counsellor of my organisation [an Australian based NGO] after receiving three and half weeks training in South Africa on counselling refugees in 2002. The trainers are from the US and Australia. I had some previous training on counselling when I trained as a social worker in the US in 1987. My counselling work is mainly for female refugees who have been abused, raped and tortured. But the problem is that most of them do not want to share their stories with me. They want me to help them financially or get access to other services. Rarely do they discuss about feelings or emotions. I get tired about their financial or service requests and they get angry with me as I push them to express their feelings and emotions. This is a very difficult job"*

An Urban Counsellor from Lilongwe, Malawi
(Direct Discussion with the Author), October, 2006[4]

Receiving two to three weeks training, most field practitioners become counsellors in countries like Sri Lanka, Pakistan or Jordan. This is totally a different situation than in Europe or the US. To become a member of the British Association for Counselling and Psychotherapy (BACP, 2008) requires successful completion of a one-year full time or two year part time counselling and psychotherapy course. This course includes a supervised placement. In the US to be a member of the American Psychological Association (APA, 2008); one needs to have a doctoral degree in psychology or a related field from a regionally accredited graduate or professional school or a school that achieved such accreditation within 5 years of the doctoral degree (or a school of similar standing outside of the United States). In addition, these membership categories provide continuing professional development, ethical supervision and monitoring as well as opportunities to meet peers from the field.

However, these readymade counselling trainings in the field do not provide any of the above opportunities to the 'counsellors' they train.

"After receiving a two and half weeks training, my organisation promoted me as the senior counsellor of the organisation [a US based NGO] in 2001. Since then I have participated in three more one week trainings. I am suppose to train new counsellors, supervise them and provide them support when they have difficulties. But I do not have any of that. Since Iraqi refugees start coming in again my workload has gone up and it pushed me to work more than 18 hours per day. I learn new skills and concepts through reading books I buy through the internet and when I meet people like you from outside. Regarding my personal life, I have minimum time for my wife and no time to spend."
A Senior Counsellor in Amman, Jordan
(Direct Discussion with the Author), November 2007[5]

This shows that the lack of ethical supervision, training or monitoring in the field. The Action Sheet 4.3 of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (Organize orientation and training of aid workers on mental health and psychosocial support, 2007, p.81) states that "essential teaching may be organized through brief orientation and training seminars followed by ongoing support and supervision. Seminars should accentuate practical instruction and focus on the essential skills, knowledge, ethics and guidelines needed for emergency response." Although this is in a document that has been agreed by all most all the international players on mental health and psychosocial support, the reality in the field does not reflect this.

The above discussions with practitioners in the field shows that these trainings have made them believe that expressing feelings and emotions is the best remedy to improve people's psychosocial status. Quoted by Summerfield (1995, p.06) "White and Marsella (1982) noted that the use of 'talk therapy' aimed at change through gaining insights into one's psychological life is firmly rooted in a Western conception of a person as a distinct and independent individual capable of self-transformation in relative isolation from social context." But the cultures in Africa, Asia or Middle East do not embody an individualistic perspective of life. People in these regions always identify themselves related to another person in the society. This community centred view of life seems to be contradicting with the Western view of individual self.

Existing Efforts and Failures

During 2007, there were efforts by the Inter Agency Task Force to field test the Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Between February 20 and 21, 2007 a field-testing workshop was conducted in Sri Lanka.

> *The workshop was filled with presentations and should have done in a more participatory manner. I don't think that one could become really qualified to implement even parts of these guidelines after a two days workshop. Also, they expect us to give feedback about the effectiveness about these guidelines within two or three months. Well, this is too much pressure and rushing. There were no discussions per say about how Sri Lanka could adopt these guidelines in to local realities. Then the workshops they conducted in local languages had so many errors with bad translations. I think that this will not produce anything effective as there is no support mechanism in Sri Lanka to assist field level problems and I am not aware about any monitoring process.*

A Sri Lankan UN staff member that work on mental health
(Direct Discussion with the Author), March 2007[6]

Further, the IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings ceased to exist by end of 2007 and hoped that the agencies would work together to continue to strengthen these guidelines (Van Ommeren, 2007, public e-mail). However, the field reality seems quite different to this hope.

We don't like the way this Working Group has been functioning. Two months ago it was one international agency that was chairing this and today we realised that there is a UN agency that is co-chairing this without consulting us as members. Then they are giving us orders on how to conduct our own projects and activities. We are going to leave this Working Group and continue to do our own activities as we used to do"

An International Agency representative about the Psychosocial Working Group in Jordan
(Direct discussion with the Author), November 2007[7]

It seems that these guidelines are not quite localised and at local level there are many issues among humanitarian agencies to work together. "Individual and international nongovernmental agencies bring their own missions and organizational strategies to their aid efforts and their managers and leaders quite naturally find it difficult to see the world through other lenses than those perspective supplies" (Scott, 2003; Quoted by Stephenson and Kehler, 2004, p.04) Further, "Donor behaviour currently represents a patchwork of policies and activities by individual governments which, taken together, do not provide a coherent or effective system for financing the international humanitarian enterprise." (Smillie and Minear, 2003, p.01) These differences and policy issues in the humanitarian sector create a situation where agencies do not necessarily work together. My own experience is that soon after the tsunami there were many agencies in Sri Lanka that did not want to co-ordinate with the UN or other agencies.

When it comes to mental health and psychosocial programs, the problem is that anyone who claims to be an "expert" could conduct whatever they want at community level. However, the communities tend to suffer more through these activities than the catastrophe they experienced.

These un-coordinated and unethical interventions in the field level often included "counseling sessions' or 'therapeutic activities' for survivors of the disaster by unknown international experts and poorly trained non-governmental organization (NGO) staff and volunteers from, despite the limited evidence to support the effectiveness of immediate post-disaster critical incident stress debriefing (Gray, Maguen & Litz, 2004).

"The foreigner who came to our camp asked all of us to list down our problems after the tsunami. We listed things like schools, education, housing and difficulties in this camp. After listening to us he said that we have mental problems as we do not want to discuss our feelings. He wanted to us to talk about our mental problems. We could not understand any of that and we left the foreigner and his workshop"

Teenage girl from Tsunami Affected Western Province in Sri Lanka
(Direct Discussion with the Author), March 2005[8]

As stated by Summerfield (1999), it is a common phenomenon that the International agencies and experts expect disaster-affected people to have emotional problems and not practical problems.

"The foreign woman who came with a translator asked me what my problems are. So I said that I want to go to school and there is no proper schooling in this village. Also, I said that my sisters and brothers do not have enough food as my parents do not have work to make enough money for food. But she kept asking me whether I have been raped or abused. When I said no, she told me that if I ever get raped or abused they are there to help me. I am really confused about this as why can't they help us now?"

Teenage girl from Umkher, Western Darfur in Sudan
(Direct Discussion with the Author), May 2005[9]

Conclusion: Morals, Ethics and Question

Morals are the base of ethics. As Kleinman (2006) says this does not mean morals are always good or positive. But different communities, countries and institutions have different moral values and ethical frameworks that others may consider as negative or bad. As discussed above, when it comes to international mental health activities, these are the universalised expectations from international agencies and 'experts' that everyone shares the same morals. As some of the discussions shows earlier this has created problematic and unethical situations in the field. Beyond that, local practitioners get confused and communities become weary with international mental health activities.

Different ethical frameworks from different contexts are based on the available morals and may not necessarily be universal. In many ways, this can be similar to justice. One person's justice can be other person's punishment. Equally, approaches that may be suitable to Western settings are not necessarily suitable to non-western community settings. Further, Kleinman (2006, p.02) argues that, "…what looks so wrong from outside may not look that way from the inside." Most 'mental health experts' that visit disaster and conflict affected countries without local knowledge of traditions and cultures judge communities from the outside.

In conclusion this article raises the following question for further research and policy discourse:

What is the real need for standalone international mental health activities in disaster and conflict affected communities?

How to develop flexible and sensitive ethical frameworks for such work?

What would be the effective approach to monitor international 'experts' going to the field and how to ensure that they won't conduct unethical activities?

References

Action Aid International (2006) *Tsunami Response: A Human Rights Assessment*, Action Aid International

American Psychological Association (1990) *Public Interest Directorate,* approved by the Council of Representatives in August of 1990 during the 98th Annual Convention in Boston, Massachusetts: http://www.apa.org/pi/guide.html

American Psychological Association (2008): http://www.apa.org/membership/join.html

Ashcroft, R. (2001), *What's the good of counselling and psychotherapy: developing an ethical framework*, Counselling and PsychotherapyJournal, 12(8): 10–12.

Bond, T, (2004), *"Ethical guidelines for researching counselling and psychotherapy",* BACP, Rugby

British Association for Counselling and Psychotherapy (2008): http://www.bacp.co.uk/join_bacp/membership_categories/ind_membership.php

Coddington, R.D. (1972). T*he significance of life events as etiologic factors in the diseases of children - II A study of a normal population*, Journal of Psychosomatic Research, 16, 205-213

Gray,M. J.,Maguen, S.,&Litz,B.T. (2004), *Acute psychological impact of disaster and large-scale trauma: limitations of traditional interventions and future practice recommendations*. Journalof Prehospital Disaster Medicine,19, 64- 72.

Inter-Agency Standing Committee (2007), *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva

Joseph, S., Williams, R. & Yule, W. (1995) *Psychosocial perspectives on post-traumatic stress*, Clinical Psychology Review*, 15* (6), 515-544

Kellehear, A, (1993) *The unobstructive researcher,* NSW, Australia: Allen & Unwin

Kleinman, A, (2006), *What really matters,* Oxford University Press

Millar, G. (2005), *The Tsunami's Psychological Aftermath*. Science **209**: 1030-33

Pupavac, V, (2001) *Therapeutic Governance: Psychosocial Intervention and Trauma Risk Management*, Disasters: 25(4): 358-72

Stephenson Jr. M and Kehler, N, (2004), *Rethinking Humanitarian Assistance Coordination,* International Society for Third Sector Research Sixth International Conference, Toronto

Smillie, I and Minear, L (2003), *The quality of money: Donor behaviour in humanitarian financing,* An independent study, Humanitarianism and War Project, The Feinstein International Famine Center, MA

Summerfield, D, (2000) *War and mental health: a brief overview*, British Medical Journal, 321

Summerfield, D., & Hume, F. (1992) *War and posttraumatic stress disorder: The question of social context*. Journal of Nervous and Mental Disease, 181, 522

Summerfield, D., & Toser, L. (1991) *"Low intensity" war and mental trauma in Nicaragua: A Study in a rural community*. Medicine and War, 7:84-99

Summerfield, D. (1995) *Addressing Human Response to War and Atrocity: Major Challenges in Research and Practices and the Limitations of Western Psychiatric Models*. In Beyond Trauma: Cultural and Social Dynamics (eds.) J. Kleber, C. Figley, P. Berthold and R. Gersons, Plenum Press, New York, 17-29.

Van Ommeren, Mark, Launch of IASC Guidelines: Thank you to all reviewers, IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings, Group E-mail on 08 September 2007

Vogel, J.M., & Vernberg, E.M. (1993). *Part 1: Children's psychological responses to disasters*. Journal of Clinical Child Psychology*, 22* (4), 464-484

Endnotes

[1] The Community Mental Health and Wellbeing Programme of Disaster and Development Centre was working in Sri Lanka in collaboration with the Green Movement of Sri Lanka on damage assessments, emergency food, shelter and medical assistance and long term housing, livelihood and social re-building between December 26, 2004 to March 2006.

[2] The Community Mental Health and Wellbeing Programme of Disaster and Development Centre was working in Sri Lanka in collaboration with the Green Movement of Sri Lanka on damage assessments, emergency food, shelter and medical assistance and long term housing, livelihood and social re-building between December 26, 2004 to March 2006.

[3] Partnership activities between the Community Mental Health and Wellbeing Programme of Disaster and Development Centre with UN Refugee Agency in Western Darfur, April to July 2005

[4] Partnership activities between the Community Mental Health and Wellbeing Programme of Disaster and Development Centre with UN Refugee Agency in Malawi, August to November 2006

[5] Partnership activities between the Community Mental Health and Wellbeing Programme of Disaster and Development Centre with UN Refugee Agency, October to November, 2007

[6] Discussion with a former colleague who is now working for the UN, March 2007

[7] Discussion with a participant of the Psychosocial Forum in Jordan, November 2007

[8] The Community Mental Health and Wellbeing Programme of Disaster and Development Centre was working in Sri Lanka in collaboration with the Green Movement of Sri Lanka on damage assessments, emergency food, shelter and medical assistance and long term housing, livelihood and social re-building between December 26, 2004 to March 2006.

[9] Partnership activities between the Community Mental Health and Wellbeing Programme of Disaster and Development Centre with UN Refugee Agency in Western Darfur, April to July 2005

Biographical Sketch

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