**Conference – Beirut**

**Issues and Controversies in Global Mental Health: Implications for the Suffering of War Affected Populations**

The experience of emotional distress is universal, but how it is understood and what people think needs to be done to help is dependent on cultural context. However, one of major aims of the movement for Global Mental Health, launched in 2007, is to actively promote the “scaling up” of Western treatments and medication worldwide. This approach has attracted criticism on various grounds, including: its focus on an individualistic biomedical model; diagnosis based on “symptoms” rather than someone’s lived experience of distress; and lack of attention to the role of social and political factors.

This paper reviews some of these issues and controversies, and specifically highlights the risks posed by the adoption of a Western global mental health approach in the current conflict situations in the Middle East region. Can this approach have value in a situation where millions of people are displaced, have experienced the effects of war, suffered the catastrophic loss of family members and, for many, loss of all the facets of their lives as they once knew them? It is argued that a different approach is needed, one which is founded on specific local values and culture, which strengthens bonds and networks, and enables people to forge new identities, even in extremely difficult circumstances. The paper concludes with an example of this approach, describing the role of Syrian refugees at a community centre in Turkey.

**Introduction**

Wonderful to be here

thank you to the organisers.

I submitted the abstract for this conference in August but I did not know that I would be working in Gaza in September and October. I will therefore be using that experience to highlight some of the issues.

**Plan of talk**

How to talk about the complex area of global mental health in such short space of time? It will only be possible to state the essence of **some** of issues which are controversial, as there are many, but all the issues have many layers and are of course intertwined and overlap with each other. This brief talk will hopefully stimulate your thinking about these issues, particularly in relation to those affected by war.

All the concerns I will mention, and many others, have been **discussed in depth by many commentators**. I have a great number of published papers and documents and would be very happy to share them with anyone who is interested. There will also be **a list of resources on the final slide.**

However, before I begin, I would just like to take a few moments for us to think about ourselves. The suffering of those involved in war is simply beyond words, and I would like to take a few moments to think about this. – either with pen and paper or just in your mind –I would like you to think about what you think your own reactions might be.

**Scenario**

**As I mentioned, we will consider Gaza. Imagine that you and your family have been fortunate to stay with relatives in Gaza city. No one in your family has been injured or killed. But you have experienced 51 days of the bombardment . Now there is a cease fire and you are returning to your house for the first time.**

**SLIDE**

Just quickly – note down or think about 10 things you might be thinking or feeling.

**We will come back to this later.**

**Establishment of the MGMH**

To begin with, just a few brief words about the establishment of the MGMH. It is considered to have begun with the publication of a series of articles in The Lancet – a British medical journal – in 2007 and 2011, but it is now a worldwide movement with a network of approximately 4,000 members from more than 60 countries, and exerts substantial international influence, including the policies of WHO.

At first sight, this all seems to be a good idea – putting mental health, most often the Cinderella of services, **on the international map**, and the work done so far -

* Highlighting the discrepancies in mental health service provision between countries – particularly HIC and LIC countries
* arguing that MH problems are among the most prevalent and disabling problems worldwide
* that the prevalence of MH problems creates a high economic burden and therefore should receive much increased resources and funding
* addressing this disparity in terms of a “treatment gap” – assuming that more MH services can ameliorate the observed inequalities
* Responding to treatment gap by scaling up Western style interventions

may also at first sight seem desirable.

However, this worldwide movement has been extremely controversial. Disagreements and controversies remain profound and there continue to be many, sometimes, acrimonious exchanges between highly regarded experts.

**Fundamental controversy**

The overarching issue is whether the type of mental health services in HICS should be “scaled up” worldwide.

 Underneath this fundamental controversy, I will mention only three out of a myriad of other issues – diagnostic systems, language and culture

**Diagnosis**

1. **Diagnosis – DSMV**

The MGMH is underpinned by the fundamental assumptions of Western psychiatry. A fundamental tenant of which is diagnosis – a process which of course will be very familiar to all the medics here. Particular patterns of symptoms are identified.as a particular “disorder” which then determines treatment – very often medication. To assist in this process reference is made to what is considered to be  the authoritative guide to the diagnosis of mental disorders, usually called DSM– the Diagnostic and Statistical Manual of Mental Disorders

The first edition was published in 1952, and the fifth edition of the DSM (DSM-5) was published in the spring of 2013. It included the addition of entirely new disorders which had not been in previous editions, and resulted in an enormous amount of concern and opposition**,** with some professional organisations even advising against its use

Of most relevance for this talk, and for the overarching controversy in relation to scaling up mental health services worldwide is that this diagnostic system is a product of Western culture, and its primary focus is on locating problems **within** an individual.

So what relevance have diagnostic categories to those affected by war? One of the ways they are incredibly important is they are most often the basis of the questionnaires which are frequently administered to establish the “mental health needs” of war affected populations.

**Questionnaires/lists of symptoms**

Prevalence of what are usually called “mental disorders” among war affected populations is usually estimated by asking respondents to complete a checklist of symptoms. A person showing certain kinds of symptom or scoring above a certain cut off point is regarded as suffering from a mental disorder.

Those who are actively suffering, during or after a war, would no doubt be astonished to know how many publications, both from academics and organisations, which list the number of people or children suffering from “symptoms” of some kind – symptoms of PTSD, symptoms of anxiety, symptoms of “depression”. There are already many such publications from all the conflicts in the Middle East.

Let us think again about your feelings about the destruction of your house, the fact that you have suffered 51 days of bombardment and cannot escape.

Would someone who asks about your “symptoms”, gain an understanding of the experience you have lived through? Would a list of symptoms reflect your worries, your terrors about the future, your fears for your children and where and how you are going to live. How you are having to make sense of what has happened?

There are many difficulties with this type of questionnaire, but the most crucial is that checklists of symptoms cannot identify **normal** reactions of distress to abnormal situations.” - which is the situation for all those affected by war.

Questionnaires used in this way also have other problems. Most often they are simply translated from English into another language and they have been validated on a different population in another country.

**Back to Gaza for a moment.**

Even though WHO is an active partner in the MGMH, I was heartened but also amazed to read the information sheet for INGOs in Gaza published by the local WHO office at the end of August, at the beginning of the cease fire. There is not time to quote this verbatim, but the gist of this publication is asking INGOs not to carry out any more MH assessments in Gaza, and warning them of the following: this is a quote.

*Most assessments take place during the first three months after the war, usually using various international tools which may not have been validated locally or within the emergency context. The majority focus on the prevalence of disorders. However, these assessments rarely take into account that distress tends to be a normal manifestation in a community affected by an emergency. This often leads to the reporting of extremely high prevalences of mental disorders in the immediate aftermath of emergencies*. “ (Aug 27th)

Why would experienced organisations not automatically know this? Why does WHO feel the need to issue this guidance?. It seems that it would be obvious to **anyone** that levels of distress would be extremely high as a natural and normal response for anyone who has experienced what has happened in Gaza, is astonishing.

What kind of distress did you feel at the destruction of your house? Rage, grief at the loss of everything, total exhaustion, hopelessness, despair, terror about the ceasefire not holding?

In 2012 WHO and UNHCR **did** publish an assessment tool to assess mental health needs but this not yet widely used. (I used a draft of parts of this for some work in Liberia) Although, it does assess “mental health needs”, and some symptoms, it focuses much more on every day functioning, and mapping available resources

1. **Language**

Let us move on to two other crucially important and inter-related issues, that of languageand culture. Issues which deserve a conference of their own!

Although we all share a common humanity and the experience of emotional distress, how we make sense of what is happening and how we feel is mediated through our own language, culture and belief systems.

Which language we speak determines **how** we understand the world and how we **make sense** of our experience and **attribute meaning to our lives**.

Each language in the world contains concepts and words which cannot be directly translated into another language. This includes ways of expressing distress and concepts and words relating to MH. Many languages have no equivalent concepts or words for mental health concepts and ideas in English that we take for granted, for example, anxiety or stress, The words “depression” and PTSD are particularly problematic. It is not that people do not experience sadness, grief and loss, or reactions to horrific events, but that they are expressed differently. Those caught up in almost all the current conflicts in the world are not native English speakers

Very briefly, the MGMH and Western diagnostic systems are products of a culture which is secular and individualistic and the language is English. Religion, which is such a strong force in this region and provides comfort and support to many, is absent, and the spiritual dimensions of being human are not acknowledged.

When you were thinking about your thoughts and feelings about the destruction of your house and all your possessions, maybe some of you were thinking in a language that was not English, and maybe some of you might have been thinking – has God abandoned me? Others may have been praying for the strength and courage to endure.

**Concluding comments**

This has been a very small “taste” of the complex field of global mental health.

There are so many other issues and controversies, I have not had time to mention – all for another time.

So, in conclusion what can be said about the fundamental controversy about the export of Western MH services worldwide?

First of all, two paradoxes -

Paradoxical that MGMH calls for the scaling up of psychiatric and psychological treatments globally when at the same time in the cultures in which they were developed, primarily in the US and UK, there are enormous problems in MH services, and the psychiatric diagnostic system and the prescription of medication are coming under increasingly severe criticism (both from those who use services and, also, even by many psychiatrists and practitioners).

The other paradox is that both the call by MGMH to increase access to psychiatric interventions because of the identified “treatment gap” **and** the call from the many detractors to abolish diagnostic systems altogether and to **halt** the increasing power of the MGMH use the same justification - human rights.

Always amazing how the same apparent “reality” can be perceived so differently.

Also, maybe the international aid sector is ahead in its thinking about these issues. In recent years there has been an increasing focus on psychosocial progammes. At the time, this was very much a reaction to concerns about Western MH professionals implementing treatments which were felt to be culturally inappropriate or even harmful to those in different cultural contexts.

The IASC Guidelines on MHPSS (2007) were specifically designed to overcome this divide, and provide guidelines for programmes in war affected populations. The new assessment mentioned earlier, only published in 2012, is another very important step in attempting to move away from checklists based on psychiatric categories.

But - The suffering of the millions affected by war is caused by political forces, and relief of this suffering will only be brought about by the ending of conflict - the responsibility of world powers and governments. A sense of safety is fundamental for good mental health. This is not possible without the cessation of conflict.

The stresses and distress associated with conflict are multiple and often occur concurrently, therefore fundamentally all distress has to be understood **within the context** in which it occurs. Also, depending on both personal and interpersonal resources, distressing events do not necessarily lead to serious MH problems. A high level of understandable distress in highly abnormal circumstances is NOT a mental health problem.

Communities exposed to violence and displacement also suffer **immense loss** – loss of place, loss of belonging, loss of identities, loss of an imagined future, bereavement. The universal response to loss is a process of grieving – this normal process, although expressed differently in different cultures, has been given surprisingly little attention.

Interpersonal bonds and social supports are not only vital for human functioning, but provide enormous support for those who are grieving, and as already mentioned, religion can play a crucial role. Restoration of social supports is the stated aim of many psychosocial programmes with war affected populations.

As in all societies, there **will** always be some who have had existing more serious mental health problems which are likely to be exacerbated by highly distressing circumstances, and who will need particular care.

But -People can be creative and resilient, striving to survive and adapt. Working with people in Gaza was an inspiration and a privilege.