New frontiers in mental health and psychosocial wellbeing in low resource and conflict affected settings

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This special, extra issue of Intervention marks the occasion of the retirement of Joop T.V.M. de Jong as a professor of cultural and global mental health at the VU University of Amsterdam. The editors of this issue are (former) PhD students and colleagues of Joop de Jong, who have been inspired by his trailblazing work. Motivated by his role in shaping the field of mental health and psychosocial support in conflict affected settings, this issue focuses on new areas of interest in research and practice that may shape the field's future. The eight articles in this special issue, while diverse, highlight major drivers of future progress for global mental health: integrating local knowledge and experiences within the larger global discourse; using multidisciplinary perspectives derived from the clinical sciences, social science and culturally informed epidemiology; attention to risk factors and disorders beyond trauma exposure and posttraumatic stress disorder; using health systems approaches; and attention to dissemination and implementation science in global mental health. The collection of papers in this issue presents new frontiers for mental health and psychosocial wellbeing in low income and conflict affected settings, and, together, point towards a potential future agenda for research and implementation of exciting new ideas to support mental health of populations affected by armed conflict and chronic adversity.

Keywords: mental health, practice, psychosocial support, research

The growth of the global mental health field

Twenty five years ago, attention to mental health and psychosocial support in low and middle income countries was minimal, and it was predominantly considered a *'luxury problem'* that had little priority compared to health conditions causing high mortality. However, the area of mental health and psychosocial support has gained prominence with increasing evidence for the proportion of global disease burden caused by mental, neurological and substance-abuse disorders (Murray et al., 2013), and with increased recognition of psychological suffering in major humanitarian emergencies, most of which takes place in low and middle income countries. While initial research was focused on estimating the prevalence of mental disorders through epidemiological research, current attention among researchers has moved to issues of effectiveness of interventions and, more recently, to care delivery models (Jordans & Tol, 2013). In the field of mental health and psychosocial support in humanitarian settings, the past decade has seen a gradual movement towards consensus on what constitutes best practices (Wessells & van Ommeren, 2008).

The increasing interest in issues of mental health and psychosocial wellbeing in low resource contexts, and specifically humanitarian settings, has resulted in some landmark publications and changes in practice. Within the academic literature, the topic has gained prominence (Chisholm et al., 2007; Collins, Insel, Chockalingham et al., 2013; Patel et al., 2012; Tol et al., 2011c), a trend that went hand-in-hand with increased financing from major funding institutions. It has also resulted in relevant changes for the practice of mental health and psychosocial care, through consensus based guidelines for implementation in emergency

settings (IASC, 2007) and evidence based guidelines for the integration of care within non-specialised health settings (WHO, 2010), with specific attention for disorders and conditions specifically related to stress (Tol, Barbui, & van Ommeren, 2013a).

The steady increase of attention for mental health and psychosocial support in low and middle income countries, and for humanitarian contexts in particular, can be explained by several factors, including the role of good practice development through research, and of nongovernmental organisations (NGOs), both of which were influenced by early innovators and organisations. The Dutch psychiatrist Joop de Jong, who worked in Guinea Bissau after it gained independence, was among those early innovators (de Jong, 1982). In the early 1990 s, he established the Transcultural Psychosocial Organisation (TPO), before 1994 known as IPSER, and since 2005 as HealthNet TPO, after a merger. This organisation was one of the first humanitarian organisations dedicated to mental health and psychosocial interventions in conflict affected settings. It has left its mark in several important ways. It did so first and foremost by advocating a public mental health approach to address the mental health and social needs of target populations, arguing that programmes have to resort to primary care and community-based models to '*protect, promote and restore mental health of a population*' (de Jong, 2002). In practice, this involved piloting concepts that are now common practice but were rather novel at the time, such as: mental health service delivery by nonspecialised people from within the community or health systems, now commonly referred to as '*task-shifting*' or '*task-sharing*' (Baron, Jensen, & de Jong, 2003; de Jong, 1996); attention to social processes in families and communities as well as to individuals with identified mental health problems (de Jong et al., 2001); as well as the use of systematic screening to triage to different levels of care (de Jong, 1987a). Moreover, it implied emphasising and addressing the (social) determinants of mental health, rather than focussing solely on treatment of mental disorders (de Jong, 1992; Patel, 2007). Second, and consistent with a public mental health approach, is the use of a multilevel care model that encompasses primary, secondary and tertiary prevention interventions, and combines actions within and outside the health care sector (de Jong, 2002). This notion is now enshrined in international guidelines for complex emergencies (Inter-Agency Standing Committee (IASC), 2007; Sphere Project, 2011) and has demonstrated application, for example, for children in areas of armed conflict (Jordans et al., 2010).

Third, the development of mental health and psychosocial care in low income countries should be done with a *pragmatic cultural lens*. There is an inherent tension in relying on treatment models from high income settings when developing such care in low income settings, with an ever-looming pitfall for ethnocultural biases and power dynamics. Together with others (e.g. Kirmayer, 1989; Kleinman, 1980), Joop de Jong and colleagues have emphasised the role of cultural context within the expression of psychological distress (de Jong, 1987b; de Jong & Reis, 2010; Ketzer & Crescenzi, 2002; Ventevogel, Jordans, Reis, & de Jong., 2013) and, subsequently, in the help-seeking behaviour of people who suffer psychologically (van Duijl, Kleijn, & de Jong, 2014), necessitating the development of service-delivery models that take local expressions into account and involve collaboration with traditional healing practices (Le Roy, 2002; Somasundaram, van de Put, Eisenbruch, & de Jong, 1999; Song, van den Brink, & de Jong, 2013). Another example of this pragmatic cultural lens, specifically with regard to populations at risk for mass traumatisation, has been the debate about the roles of culture and context in traumatic responses, and the crosscultural applicability of posttraumatic stress disorder (PTSD) as a nosological category (de Jong, 2004,2005; de Jong et al., 2005).

Fourth, the convergence of both research and practice into one programme is an instrumental strategy to bridge two domains that have traditionally been divided, with academic institutions primarily focusing on the former and humanitarian organisations on the latter. However, research and implementation should be two sides of the same coin, with research influencing the nature of interventions (in needs assessment, programme design, and monitoring and evaluation) and issues important to implementation featuring centrally on the research agenda.

Finally, NGOs can be an important vehicle to build human capacity in contexts where there are limited human resources to provide good quality mental health and psychosocial services. While fraught with many challenges, for example difficulties with sustaining programmes, NGOs in many humanitarian settings have been the main, and often the only, mental health and psychosocial care providers, training large numbers of nonprofessionals as a result (de Jong, 2007). This is salient given that, in fragile or low resourced settings, formal training programmes (by national governments or local universities) are often not adequately resourced or adapted to independently cater to the needs in human resources to provide large-scale care.

The retirement of Joop de Jong provides a timely opportunity to take stock of what has been achieved in the field over the past decades, as well as an opportunity to look forward. The aim of this issue is to provide food for thought and discussion of new directions that have the potential to strengthen mental health and psychosocial interventions in the period to come.

New frontiers in mental health and psychosocial support in eight papers

The collection of articles in this issue opens with a thought-provoking paper by *Vikram Patel* (2014), who argues for a paradigm shift in global mental health, from using chiefly '*supply-side arguments*' ('*there are not enough services and professionals*') to reduce the treatment gap (i.e. the proportion of people with a mental disorder in a population who are not receiving mental health services) to a more demand-side perspective. This entails changing how mental health professionals think and speak about psychological suffering in order to bridge what Patel calls this the '*credibility gap*': a lack of connection between how people in low and middle income countries perceive and address psychological distress and the way mental health professionals do this. Particularly bold is Patel's suggestion to stop using prevalence estimates generated by standard epidemiological surveys to define the number of people in need of treatment. As he argues '*only a small fraction of the global population truly believes any of the astonishingly large figures that these surveys throw up*'. This argument is not new; the validity of estimated prevalence rates has been called into question particularly in humanitarian settings (Bolton & Betancourt, 2004; Rodin & van Ommeren, 2009; Summerfield, 2008; Ventevogel, 2005), but Patel's paper urges the field of global mental health to establish its credibility outside of circles of academics and researchers in a way that makes most sense to people who are suffering adversity and distress. In order to do this, it is of vital importance to take culture and context seriously. It may require a new culturally informed epidemiology (de Jong & Komproe, 2002; de Jong & van Ommeren, 2002; Kohrt et al., 2014) that incorporates contextually relevant aspects of social functioning (Tol, Komproe, Jordans et al., 2011b), uses locally salient expressions of distress (Nichter, 2010) and measures what is relevant for people themselves in their daily lives (Kleinman, 2004).

In another paper in this issue, *Stevan Hobfoll* (2014) also suggests a shift in thinking around the delivery of mental health and psychosocial interventions, based on his conservation of resources (COR) theory. This theory, focusing on the resources that people can

rely on in the face of adversity, can serve as a common framework for actors in diverse sectors such as health, education, (child) protection and social services. These actors have traditionally given different answers to the question of what the highest priorities for mental health and psychosocial well-being are in low resource settings. Hobfoll highlights how adversity commonly accumulates over time, with one adverse circumstance or event increasing the risk for further adversity. This is highly relevant, particularly in situations of continuous social suffering and collective violence as it may help explain why and how some people become badly affected by potentially traumatic events and others less so (cf. Paardekooper, de Jong, & Hermanns, 1999; Punumäki, Komproe, Quota et al., 2005). Hobfoll's COR theory brings together in one framework the negative social conditions that structurally and chronically undermine one's ability to maintain positive mental health (i.e. child abuse and neglect, chronic poverty, gender based violence, social marginalisation), and the importance of exposure to time-bound potentially traumatic events. Furthermore, this attention for resources, and the connection of resources in time and space as resource '*caravans*', may inform the currently popular interest in resilience, i.e. the ability to maintain wellbeing despite exposure to adversity (Hall, Tol, Jordans et al., 2014; Tol, Jordans, Kohrt et al., 2013b).

Over the years there has been much debate about the role of trauma and PTSD in mental health programmes in humanitarian settings. The main critique has been the predominance of attention to crisis-related traumatic events and resulting PTSD in research and treatment of people exposed to organised violence, often at the expense of attention to other priority mental health and psychosocial problems (de Jong, Komproe, & van Ommeren, 2003; Tol et al., 2011a), such as the importance of addressing ongoing daily stressors as causes of distress (Araya, Chotai, Komproe, & de Jong, 2007, 2011; de Jong et al., 2001; Laban, Gernaat, Komproe et al., 2005). *Kenneth Miller & Andrew Rasmussen*, who previously elaborated such a critique (Miller, Fernando, & Berger, 2009; Miller & Rasmussen, 2010), now take their conceptualisation a step further and propose a transactional model that factors in the '*experience of chronically elevated stress punctuated by intermittent potentially traumatic events*', combining the negative impact of an ongoing stressful context with discrete traumatic events (Miller & Rasmussen, 2014).

Such a transactional model corresponds well with the paper by *Daya Somasundaram* (2014) aimed at understanding the impact of living within a context of ongoing violence (in this case Sri Lanka) at a collective, rather than individual, level. Somasundaram eloquently argues that perpetual emergencies fundamentally affect social processes, dynamics and functioning. Intervention programmes, therefore, should target individual and community wellbeing through encouraging positive social processes such as beneficial traditional practices, promoting positive family and community relationships and mobilising grass root workers.

Research with conflict affected populations requires a thorough understanding of the context and of how people themselves make meaning of their experiences of adversity. This calls for mixed methods research in which ethnographic research methods are combined with methods that focused on measuring and analysing quantifiable data. *Stevan M. Weine, Aqsa Durrani & Chloe Polutnik* (2014) conducted a systematic research for articles that utilised mixed methods to investigate refugee mental health. They found 29 articles, mostly based on research carried out in high income countries. This relatively modest body of research has important value: mixed methods research helps to improve understanding challenges and burdens for refugees from their own perspectives, particularly when it comes to experiences related to loss of social

connection or social status, and difficulties to access appropriate services. As Weine and colleagues argue, a participatory research approach may involve not just studying how an intervention works but also how interventions are experienced and perceived by community members. This is of critical importance to develop interventions that make sense to the people involved and will help speed up dissemination and implementation.

The importance of mixed-methods research is clearly demonstrated in the paper by *Devon Hinton & Baland Jalal* (2014), who provide a framework for adaptation of cognitive behavioural therapy (CBT) techniques for use with refugees, in order to arrive at '*contextually sensitive*' CBT. They provide a timely overview of key issues to consider in attempting this, which include: detailed attention to linguistic, religious and socioeconomic characteristics; attention to what the target group perceives to be key stressors, resources and mental health issues; and considering issues related to metaphors, barriers to access and stigma.

Having a well conceptualised intervention that shows benefits in rigorous evaluation studies is necessary but not sufficient to make a difference in the real world. To achieve this, interventions should ideally be implemented on a larger scale and for longer periods. *Laura K. Murray, Wietse A. Tol, Mark J.D. Jordans, Goran Sabir, Ahmed Mohammed Amin, Paul Bolton, Judith K. Bass, Francisco Javier Bonilla-Escobar and Graham Thornicroft* (2014) argue that the crux of success for many interventions is to improve knowledge on how to implement such interventions at a larger scale. This requires designing treatments that are compelling and effective across a range of contexts and populations, but also remain adaptable to specific contexts and may even require changes *within the context*. The latter involves a range of actions such as engaging with policy makers, installing supervision systems, addressing stigma and mistrust of potential service users. The call of Murray and colleagues to have more attention to '*dissemination and implementation research*' is justified, and is consistent with the objective of this journal, which seeks to bridge science, practice and policy.

Finally, a richly documented case study from *Nawaraj Upadhaya, Nagendra P. Luitel, Suraj Koirala, Ramesh P. Adhikari, Dristy Gurung, Pragya Shrestha, Wietse A. Tol, Brandon A. Kohrt & Mark J.D. Jordans (2014)* describes the important role of local NGOs in the development of mental health and psychosocial support services in Nepal, as in many postconflict settings. Many of the points mentioned in this introduction are illustrated here: the importance of tailoring interventions to local context, the need to have research and implementation go hand-in-hand and the overriding need to build local capacity. An organisation that played a key role in the remarkable development of mental health and psychosocial support services in Nepal is an offspring of the Transcultural Psychosocial Organisation, which had been active in Nepal in research and implementation since the mid 1990s (Shrestha et al., 1998; van Ommeren, Sharma, Sharma et al., 2002).

Conclusions

This issue, as a tribute to Joop de Jong's pioneering work, aims to look towards the future. The papers in this issue are a testimony to the fact that the field of mental health and psychosocial support in postconflict and low resource settings has made significant progress. The diverse set of papers highlight what we regard as major drivers of future progress for global mental health: integrating local knowledge and experiences within the larger global discourse; drawing from a range of perspectives derived from clinical science, social science and public health; using broad and inclusive definitions of adversity, moving beyond attention to a narrow set of risk factors and mental disorders to include a broader view of the complex individual and social processes that shape mental health. We urgently need more

knowledge on how to best merge the benefits of local cultural practices with those of global biomedical approaches to mental health; on how to develop mental health care systems that are feasible and sustainable; and on demonstrating the cost effectiveness of interventions and their impact on reducing the large burden of disease associated with mental health problems. We hope the voices in this issue will inspire practitioners, researchers and policy makers to embrace these exciting '*new frontiers*' in research and practice of mental health care in low and middle income settings, and particularly in complex humanitarian emergencies.

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