

*Personal reflection*

# Mental health and psychosocial support in the face of Ebola in Liberia: the personal and professional intersect. A personal account

*Janice L. Cooper*

*This personal reflection is based on the author's experiences, a native Liberian, in her country at the beginning of the 2014 Ebola epidemic. It includes her account of events as Ebola cases and related deaths began to rise and the response appeared inadequate. Examples are presented where a robust psychosocial and mental health response was critically required, but most often lacking. This reflection focuses on the points where the author's personal and the professional life met as she co-led the psychosocial pillar of the national response team on Ebola. It also explores the challenges of leading the mental health and psychosocial component of a complex emergency within a fragile, post conflict state, where the medical and infectious disease component of the response often takes precedence. Additionally, the author's internal struggle that occurred when she was forced to evacuate at the outbreak's peak is explored.*

**Keywords:** Ebola, Liberia, mental health, personal protective equipment, psychosocial response, social reactions

## Introduction

My job as support to mental health programme in Liberia is a dream job. Through it, I have met many wonderful people and been involved in the training of nearly 145 clinicians. In that respect, my work has allowed me to substantially contribute to dealing with the threat of Ebola on both individual and society levels. I work in a suburb of Monrovia called Congotown, less than 1.6 kilometres from the Ministry of Health, in a compound with other nongovernmental organisations (NGOs). I lead a mental health training and

anti-stigma programme that has a policy support component, which has trained mental health clinicians from across the country. In late June of 2014, I was asked to join the Ebola National Taskforce, now called the Incident Management System, as the Co-Chair for the Psychosocial Pillar.<sup>1</sup> Since joining the Ebola response, my office is now at the Ebola Command Center in Sinkor, Monrovia. I live in my family home, located approximately 8 kilometres from Monrovia. This house and its yard has a long history, much of it rooted in difficult times, some in happier ones. In 1980, my mother was arrested here and taken to jail. In 1988, friends and family attended my wedding reception here and, in 1990, this is where I fled with my husband and toddler when fighters came to my house. This is where we stayed, along with nearly 200 other people, until caught in a firefight between the 'peacekeeping' forces of The Economic Community of West African States Monitoring Group (Ecomog) and the 'freedom fighters' of Charles Taylor's National Patriotic Front of Liberia (NPFL). When forced to flee again it was into what was then called 'Greater Liberia'.

## First days

When I and my team first heard about Ebola in Lofa County in March 2014, the north of the country, it was with no real alarm. Within days we found out that a Médecins Sans Frontières (MSF) team was on the way, and most people relaxed into the notion that the Ebola Virus Disease (EVD) would



*Figure 1: Political map of Liberia (source: <http://www.mapsofworld.com/liberia/maps/liberia-political-map.jpg>).*

now be contained far away from us (Figure 1). During early April 2014 it seemed that the outbreak was contained, but then it came closer. We heard the story of a woman with EVD and her young baby, they had taken a taxi a long distance to meet her husband in Firestone, site of the famous rubber plantation. On the way, they had stopped and the taxi driver found a place for her to sleep. She had been vomiting and the taxi driver was her default caretaker, cleaning up after her. When she finally reached her destination, the stigma was immediate. The hospital initially refused to treat her, even though her husband was an employee. At this time

schools were still operating and although she had not been in contact with her children since becoming symptomatic, there was a move to keep her children from school. Understanding the disease was new to everyone, and the natural reaction was panic and fear. As more education reached the public, there was clear vacillation between denial and over reaction.

**Denial, mistakes and fear**

Ebola got my attention when, as part of the continuing education component of our mental health training, we held a workshop on communications disorders in children at the prestigious Cape Hotel in Monrovia on

12 April 2014, led by a professor from Makerere University in Uganda. Sixty mental health clinicians attended. The anxiety of the clinicians in the room was palpable, as the initial update session featured an update on the epidemic from Lofa County. A clinician who was leading the mental health and psychosocial support (MHPSS) side of the response from Lofa county outlined her work with the county health and social welfare team and reassured us that all was well. Everything was under control, and there was sufficient personal protective equipment, known locally by the acronym PPE. Her presentation triggered many responses, mostly protestations that even if this was the case in Lofa, it would not be the same in other counties. Then I asked a clinician (referred to here as Jonathan)<sup>2</sup> from the epicentre of the epidemic, Foya in Lofa County, to speak. A soft-spoken man, he discredited all that had been said by the clinician from Lofa county, saying that he had seen no evidence of widespread availability of PPEs. Jonathan was stationed in the hospital where the MSF Ebola Treatment Unit was built. He informed the group of a case of a health care worker who had been infected, went home and later became sick, exposing his family without contacting the centre or the supervisor. The worker died. This was a telling sign that our downfall would be a health care system pieced together with the best intentions, but lacking the basic elements of what we mean by *'system'*. Apparently none of the nursing supervisors had received the message that when someone does not come to work, or calls in sick, they should physically seek out this person. This mistake has been repeated throughout the epidemic. Following Jonathan's presentation, there was an animated discussion among the clinicians on the ways that this virus might permeate a frayed health care delivery system. Most clinicians had not been paid for months, and their union was in a dispute with the government on issues of pay and working

conditions. On top of that, as the clinician had said, there were not enough PPEs, in fact, many had not even seen a PPE.

### **The spread of Ebola and lack of support of health care workers**

Shortly after that training, I joined the response programme to support the existing psychosocial committee. We met daily and on weekends. More and more people from the international community seem to appear at these meetings. Few were emergency, let alone EVD, specialists. There were polite acknowledgements that MHPSS was important to the response, but most of the support was focused on food, meeting basic needs and identifying contacts of cases that could be listed and passed on to the contact tracing team. One of our international faculty conducted training on Ebola and its psychological effects with the Ministry of Health & Social Welfare. In the regular response meetings the stories started to come. A whole family wiped out because they attended a funeral. Cleric after cleric became infected, and infected others, as they carried out burial rites. During this time, we continued to have classes and my students brought in stories of their own. The number of cases rose and then the dreaded fear happened, Ebola hit Monrovia. Elsewhere across the country, regular health services started to shut down amidst claims of insufficient protective gear and health care workers fear. Within a matter of weeks, cases were coming in from the West, the East and the South.

In Monrovia, my students spoke of their own experiences. One was threatened with eviction from her house and community because she had called an ambulance when a woman who was sick died after exhibiting symptoms of Ebola. She hung around to make sure the community would not bury the body on its own. The ambulance took most of the day to come and the clinician, a new mother, was threatened throughout this period. She stood her ground, but no longer felt safe in her community.

During daily reflections students reported what they were hearing from their own communities across the country as they talked constantly with family and co-workers about the epidemic. A group of clinicians from Gbarpolo County, north of Montserrado, heard about colleagues at home that were being instructed to conduct awareness-raising sessions within the communities, but they were afraid because they had not been given gloves nor any other basic protective equipment, and most were unpaid.

Across the country health care workers were feeling unprotected. The few students from Lofa would get daily reports about friends, mostly other health care workers, becoming infected or dying. There were reports of a friend's child on one day, a student nurse on another. In Monrovia, we knew of cases at Redemption Hospital as health care workers were infected and moved to the JFK Hospital's Ebola Treatment Unit (ETU), around the corner from our classroom. Some of the students spoke daily to their friends who were in the ETU.

### **Role of religion and lack of infection control**

One day, the President declared a day of prayer, but did not declare it a holiday. Some of the students were angry. It should have been holiday so people could *'really pray'*, some said. As we debated, it became clear the role that organised religion was playing in the epidemic. One clinician talked about people in the community who believed that the *'application of holy oil'* had protective powers, and that the now standard hand washing procedures being recommended could be ignored. There were reports of *'prayer women'* and other clerics who were *'laying hands'* on those with Ebola, thereby spreading the virus. Other issues started emerging. Some clinicians were working at their regular jobs, and then in private clinics. These clinics were among the ones identified as treating patients with Ebola. Some were treating individuals in their own homes or in patients'

homes. In many cases, there were serious concerns surrounding the absence of infection control procedures.

### **MHPSS not seen as an essential component**

Almost seamlessly our morning programme had changed. Every day began with an Ebola update that I delivered based on National Task Force meetings from the day before. At the emergency task force, things were changing too. There were lots of discussions about which parts of the response were not working well. There were many heated exchanges about what should be driving the response: the epidemiology, case management or contact tracing? At no time was MHPSS seen as essential to the emergency response. There were no resources directed at dealing with the impact of stress, trauma, grief and loss that were occurring, as the health care system began to unravel and the consequences of the epidemic became clear. Consequently, the part of MHPSS that got attention and funding related to providing food to the affected families, as contacts of Ebola patients were more likely to stay home.

On 10 July 2014 something changed. The head of case management brought to my attention the situation of a woman at the ETU who was really unwell. I called an experienced clinician (Yolanda) who, without hesitation, agreed to accompany me to the ETU. I had not been to one before. As I walked to the unit, seated outside was the clinician (Jonathan) from Foya. Instinctively I went to him and gave him a hug. He smiled sheepishly. What are you doing here, I asked. He told me that he was in Monrovia for our upcoming workshop, led by an Emory University professor, on outcomes based management, but he had felt unwell and came to be tested. I am not sure if it even registered that I had just hugged someone who was suspected of having Ebola. I moved on with Yolanda, because we had a task at hand. The woman we had come to see was

a health care worker who should have been discharged the night before, but was still there as she had refused to have her blood tested to confirm that she was negative for the virus. She was not exhibiting any symptoms of Ebola, but had been there for more than 21 days. Now she had become aggressive and violent, and had set a small fire. She was combative and verbally abusive. As Yolanda and I entered the ETU we were met with a surreal sight. The sun was blistering hot. The sick health care worker, Pamela, sat on the ground playing with a large plastic tub, methodically moving sand in and out of it. Her hair was loose and wild, and her navy blue outfit was covered with sand and clung to her body. She was mostly talking to herself, but when we approached her and introduced ourselves, we became the target of her rants and abuse. In between ranting, she told us what it was like in her head; she saw dead bodies. She wanted water, so we got her water as most of the staff had evacuated the area because they were afraid. There were patients in the ETU that needed attention and others waiting to be admitted. There were a couple of bodies in the ETU that could not be moved. One of the only two ETUs in the city could not admit any more patients because one patient was in the middle of a psychotic episode. The lack of mental health services had effectively stopped the operation of this facility. We had been called because she was deemed a danger to the ETU. The ETU staff that had remained threatened to walk out because they were afraid of what a person suffering from psychosis might do to them. Despite our best efforts at talking and attempting to de-escalate the situation, Pamela remained aggressive and combative. In between her curses, with some choice ones addressed personally at me, she suddenly remembered me and I her, from her clinic. She told us how impersonal she feels the PPEs are, and how inhuman the people who don them must be. She complained of the lack of human touch. Her pastor arrived,

but she chased him out with more abuse. Outside, he told me that he had treated her seven years ago in his church to rid her of *'her demons'* and that she had remained with him for many months. She had been shackled and bit him in the thigh. If there had been a proper assessment with that history when she was admitted, I thought this current crisis may have been avoided.

Outside the ETU, a truckload of policeman (from the emergency response unit) was parked. They had been called as the authorities feared the situation could escalate. Their riot gear and armour were irrelevant here however, as if she charged at them, they would simply flee. This is the fear of mental illness. She is asymptomatic and our knowledge tells us she is not infectious, but could it be that she is? Could it be she is *'strong'* and still has the virus? After several unsuccessful attempts to talk her down, we discussed the possibility of a more invasive procedure with the MSF doctor.

In the end, four men approached her in full PPEs and struggled to physically restrain her as another doctor give her a shot of 100 mgs of Thorazine. We waited for her to calm down while the clinicians assess whether they have enough Thorazine in stock. She seems calmer by the time we left. The plan is to be back in the morning, and if things start getting lively again to be in touch with the clinician. As we waited for the car outside, Yolanda put her umbrella down where our colleague from Foya had been sitting. Dr. Zaizay, the lead clinician in the response, came to us and said; *'your umbrella is where a suspect has been sitting'*. On the way home we do not talk much, we have entered the response rather dramatically. Mental health is on the map.

That evening Yolanda received calls every hour, sometimes every half hour. At 11 pm she sent me a text saying the facility manager had *'called saying she is combative again'*. She had augmented her initial drug order, but still this did not seem to calm the client for more than a couple of hours. At 3 am she texted again, so I asked if they were able

to take the blood sample, she responded by text that *'he said no because she was only calm and did not sleep, so she refused'*. At 4:40 am my request for help was answered via email by our consultant psychiatrist at the other end of the continent who responded to the question what should we try next? She suggested changing the medication. Armed with this information, we stopped at the only mental health hospital in the country to pick up the recommended Haloperidol. On arrival, we learn that our client has scared the staff into leaving the facility again.

Yolanda leaves instructions to administer the Haloperidol in the suggested dose before we go off to the workshop. In the workshop, Yolanda makes many calls to ETU supervisor Nelson, checking on the status of the patient. She was doing much better. Later that day the patient will have her blood drawn for her Ebola test.

The workshop Jonathan had intended to attend happens without him. His test results were indeterminate, so we have to wait for another test. At the workshop, 60 clinicians sign up to help with individual, group and phone counselling sessions for persons with Ebola. I am awestruck by their generosity. The concern and near panic that surfaced at the workshop in April, just three months ago, has now been replaced with a resolve to help, even in the face of the fear we all feel.

As I prepare to leave the following morning, I receive a text from Dr. Zaizay; *'repeat test is negative! Plan is to move her to Grant tomorrow. This calls for a celebration. One more survivor among health care workers! Thank you.'* (Grant Hospital is the country's only mental health hospital.) I called Yolanda and we are so happy that the ETU is ready to discharge our client, but in a subsequent phone call, Dr. Zaizay explains we have another problem. Her pastor wants to take her to his church instead of the hospital. I speak to her father who was there when we were working with her and I had spoken with him about her situation. Talking to him

again, I was devastated to learn he would not wait for me to come, and would not agree for her to be transferred to the mental health hospital. Some fifteen minutes later, I was still trying to convince the pastor, who took the phone next. I did not succeed. She went to the church.

Buoyed by the partial success of the client in the ETU, I approached the next EVD taskforce meeting with a sense that those staffing the psychosocial subcommittee had gained credibility by our response. The importance of MHPSS was clear. MHPSS was now on the map. Or so I thought. My high spirits were short lived as news came of the confirmation of Ebola for Jonathan. Back then, recovery rates were lower, there were fewer treatment units and people often got to them too late. We did all the normal things, purchased lots of juices and all the immune boosting foods we could get our hand on. I called him. At first he didn't answer, so I texted him. When I did finally speak with him, I reminded him about his training and what we know about mental health's impact on the immune system, so it was important for him to remain positive. It was the last time I spoke to him. The next day a colleague called to break the news, Jonathan didn't make it. Two days later we buried him.

### **The consequences of fear**

At that stage of the epidemic, cremations were not being carried out. As we drove to the cemetery with the team, after having waited most of the day to receive the body, we were also negotiating to have the same team that did the burial disinfect the house for Jonathan's wife and children. At the cemetery, there were lots of people commenting on how *'Ebola was not real'*, rather this was a government effort *'to steal kidneys'*. As the burial team went in, the immediate family and I moved away from the site. What ensued was shocking. As the jeep with the Jonathan's body moved towards the open grave and community folks recognised the Ministry

of Health's insignia, a crowd assembled. The burial team dressed in their full PPEs was all business, while near the graveside there was a small crowd. However, at the entrance to the cemetery more and more people were gathering and they seemed increasingly agitated and threatening. There were loud debates about an Ebola burial in their cemetery. My colleague Mark urged me to leave in one of the cars, while Jonathan's wife would follow with him. As they and the burial team left, they were pelted with stones by a very angry mob.

Situation report 37, 27 July 2014: 321 cases, 25 health care worker deaths, 155 total deaths

### **The personal and professional intersect**

It is Sunday 27 July and I am on my way to church. The little chapel where I worship has a beautiful spirit. I started going there with a good friend. She liked it because it was multilingual and we worshipped sometimes with hymns in Spanish and English. I liked it because it was a good experience and was usually over within an hour. It also allowed me to kill two birds with one stone: I could meet with family who lived in the compound that encompassed the Catholic Hospital, one of the major faith based health institutions, and I could go to a service which still left enough time to take up my other passion, sitting on the beach and watching the waves on a Sunday. This day, people were huddled outside the chapel, deep in animated discussion. The week before, I had had a bit of a row with one of our faith leaders. He had reported, after the service, but before we had left, that the Catholic Hospital had experienced its first Ebola case. The message to the small congregation was that Ebola was real, but it was also laced with strong criticism of the government and their response. In retrospect, he was probably infected then, but

we did not know it. After mass, he and I had some words on the hospital's responsibility to take part in the response, attend meetings and engage in the process as other hospital leaders were doing. So, on this day, the animated discussion I met was geared towards me. One of the brothers was sick, he would not be in church today, but we were told it was not Ebola. This religious order ran the hospital. The discussion was not about this, but about how quickly could I (everyone was aware I was part of the national response) get a team to the house of a family from Ghana who had a dead body in their sitting room. I called the head of the psychosocial team (I was her co-lead) and she started begging and cajoling the already severely stretched burial team. It was Sunday, 27 July 2014 at 9:26, four minutes before we started mass. Sadly it took several days after that Sunday morning to have the remains removed. In the meantime, the family spent nights in their car and days on the phone to me and anyone else who would listen. While I was instrumental in the removal, it was embarrassingly late.

The Sunday that initiated my involvement with that family would be a turning point in my relationship as part of the response. It would also change my relationship with my church. I was now seen as the *go to* person for one of our religious order when something related to Ebola happened. Within days, I was being called about sending one of our leaders to Ghana for treatment. By then, we had heard of the horrendous case of Patrick Sawyer, where Liberia had exported its first Ebola case to Nigeria. A clampdown had been put on travel of any one who was sick, irrespective of their status. The hospital and faith leader could not leave. As the days passed, he was not at church and he became sicker. There were rumours about the numbers of people who were supporting him, but not adhering to universal precautions. The brother who was my link to our church leader denied that this was Ebola.

At an emergency meeting, I was in the unusual position of asking one of the response medical leads if it was possible to force members of my church community into an Ebola treatment unit. They were not interested in going to the ETU. The head of case management was in a dilemma: should they keep people who are semi-quarantined where they are, and take other people who are willing to go to the few bed spaces that exist? Those in the church community's compound were only *semi-quarantined*, however, because as they got sick, other religious members were infected, and another brother and hospital staff were going in to help them. The brother, who was my link, also got sick and we heard stories of him going to the hospital grounds to buy telephone cards and vomiting on or near the security post.

Then, we started getting news of death. The hospital and religious leader died. I got word that a favourite nun was infected. To my dismay, they had continued a planned programme to welcome a new nun, who had returned from training. I called her the first week in August, by then, she was sick. Three days later, I got word that she had passed and was buried behind the hospital. By this time, several trips were made by case investigation teams that visited the hospital compound in an attempt to persuade them to go to the ETU. In the end, on the compound in addition to those in the religious order, themselves health care workers, were others who were assisting them. They finally agreed to be taken to the ETU. In all, nine individuals died from the outbreak at the compound.

Situation Report 10 August, 662 cumulative cases; 344 deaths; 35 health care workers' deaths

As I dealt with the very personal side of the epidemic, I was also internally battling with the decision made by my employer that I mandatorily evacuate Liberia. Many international organisations were grappling with decision of

whether to keep their senior staff in Liberia, or evacuate. At the same time, with the International Committee of the Red Cross (ICRC) and the Ministry we began training social workers and mental health clinicians in psychological first aid. It was very hard. I thought of resigning. How could I be asked to leave at such a vital time? How do you say to a population that *'we are with you and good luck'* as we left? I had dodged this question of when would it be appropriate to leave repeatedly. I was in good company. After an announcement that the US Embassy would not evacuate, they were compelled to evacuate all non essential staff. So my bosses made the decision that I should go. I was devastated. As I announced to the psychosocial committee that I would be leaving, I pushed back tears. For me, this was very difficult. During the 1990 war, with an 18 month old, having survived abduction and detention in the military barracks by the *'freedom fighters'*, we felt we had no choice but to leave. The 14 year old conflict had many phases, and while many of my friends and colleagues who were nurses and physicians were able to return, without clinical skills I had been unable to get a job that would allow me to return. This time, when many were leaving, I did not have dependants in the country. This time, I felt I could contribute.

As the day for me to leave approached, I rationalised about how much peace I was giving my family who lived in the USA. My children, my mother, my siblings had all been sending messages that were increasingly desperate in tone.

By 11 August 2014 I was out of Liberia. This was the peak of the epidemic. Within a week I was reviewing situation reports from Monrovia and hearing how horrible the situation was becoming. I was hearing more news of people who had been infected that I knew personally. Within two weeks I was itching to return home to Liberia, and was making everyone in my office miserable. Another colleague raised money to support putting trained mental health clinicians into the community to conduct dialogues and provide psychosocial support. We were grateful

to have them in the communities and by then, many were being hired to work in Ebola Treatment Units as well. By 18 September 2014, I was on a plane back to Liberia.

Three days after I arrived back in Liberia, the Situation Report for 21 September 2014 indicated 3272 cases, 1709 deaths and 85 health care workers deaths due to Ebola.

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<sup>1</sup> In Liberia there is a five pillar approach spelled out in an Ebola regional framework, comprising: (1) Beneficiary Communication and Social Mobilisation; (2) Contact Tracing and Surveillance; (3) Psychosocial Support; (4) Case Management; and (5) Safe and Dignified Burials (SDB) and Disinfection.

<sup>2</sup> All names are fictitious.

## Personal reflection

# The travellers dance: how Ebola prevention measures affect day to day life

**Teresa Gonzalez**

*While the international community remains concerned and focused on the potential spread of Ebola out of Africa, the author states that they also frequently ignore the deep psychological pain that the measures implemented to combat the disease are causing within impacted communities, as do the national authorities. She provides a snapshot of this moment in the crisis and highlights the painful impacts, dehumanising measures and makes a plea for international organisations to do more to be mindful of this pain.*

**Keywords:** burial, Ebola, everyday life, prevention, quarantine, Sierra Leone, stigma, virus outbreak

## Landing in Sierra Leone

On arrival at the airport in Sierra Leone, you are invited to wash your hands with a solution that smells strongly of chlorine. As you exit the plane onto the runway, people crowd around the arrivals door, like in many other African cities. However, in Sierra Leone, a man observes all travellers and inducts them into a new routine, one where the main message is: *DO NOT TOUCH*.

Waiting for their luggage, some people are already wearing gloves, masks or both. All along the way from the airport to the city travellers seem to perform a strange dance,