

Psychological support during an Ebola outbreak in the Democratic Republic of the Congo

Eva Paglia

In this paper, the author reflects on her personal experiences as an expatriate psychologist, in the Democratic Republic of the Congo, during an outbreak of Ebola haemorrhagic fever in 2007. As there is still no cure for this highly contagious, fatal disease, segregation from those infected appears to be the only preventative solution. This has quite different impacts and consequences for local people than for expatriate staff. Yet, in their quest to find meaning and to deal with the horrible events that took place, expatriates, staff and local people all felt powerless.

Keywords: Democratic Republic of the Congo, Ebola haemorrhagic fever, ethnopsychiatry, psychosocial intervention

‘To work as an humanitarian worker, as well as any other job, asks to use resources, curiosity and creativity to face up to the rapid changes – of culture, of colleagues or even of contexts – in which we live. And there, nor models, solutions, ready-made answers, or modes of employment are available. Often our main resource, it is our selves and our ability to create and maintain links and relationships.’

Maximilian Zimmermann, Stress Management Support Officer (Médecins sans Frontières, personal communication, 2007)

Introduction

In September 2007, I was sent on a mission, with the nongovernmental organisation (NGO) Médecins sans Frontières (MSF),

to the region of Kimpungu (Kasai Occidental) in the Democratic Republic of the Congo because of an epidemic outbreak of Ebola hemorrhagic fever. This is an extremely contagious disease, for which there is no vaccine nor cure. The Zaire-type of Ebola kills 70 to 90% of those infected. MSF’s activities, therefore, focused on isolating infected people, rehydrating them, and easing their pain. In very few cases, this helps patients to recover. Otherwise, regardless of recovery, such interventions make patients more comfortable.

In order to contain the outbreak, it was important to search for other cases, and to trace those who had been in contact with people suspected of being infected. My task was to provide psychological support to various groups involved in coping with the epidemic: expatriate health workers, national health staff who had had contact with the disease on the ground, and families of affected patients. This support to the patients’ families and *contacts* (families who had lost one or more relatives, or persons who had been in contact in one way or another with the virus) was given by exploring their (social relations) support systems, their alliances (family, tribal, and ancestral) and the treatment approaches undertaken before, and during, hospitalisation. This also included probing into their meaning of this epidemic, and evaluation of the fear related to hospitalisation, and

the compulsory isolation. In fact, isolation coincided too often with eventual death.

Devastating effects of Ebola

The explanation of the disease according to the medical point of view was always integrated into a deeper discussion involving their cultural meanings, rituals and social understanding.

Vignette 1

A young man, around 35 years old, and pastor of one of the thousands of churches operating in the Congo, was shouting in unbearable pain and was asking his father to do something, at least to hold his hand. The father, beyond the barrier that was separating the clinic environment and visitors, shook his head in mourning. The mother and the sister of the patient, were sitting on a mound a little further away, had a desperate look. The father, standing next to the barriers, began to shout out his disbelief at the possible impending death of his son, by indicating to the right and left that everything was in order in the family. His debts had been paid. Why, then would his beloved son have to die? If this suffering was conducting his son to death, he, the father would have wanted to die before his him. Then he went to sit far away on a stone in the ground, in front of the isolation room where his son was dying of Ebola, and he continued to weep. Shortly after, with the help of a translator, I spoke with this father and his wife who were losing their eleventh of their 14 children. All 11 children had died of Ebola or one of the other infectious diseases, such as Shigella or typhoid fever, that have decimated many families in the area of Kampungu.

By learning and informing me day by day on the characteristics of the disease, thanks to the scientific support of the medical team,

I was able to see the subtlety and insidiousness of this virus. The main outcome proved to be that it was perceived as an entity that forced people to fight it through self protection: do not touch each other in any circumstances, and do not wash or touch the dead. The medical team was forced to treat patients wearing appropriate clothing. This protection drove them to a form of individuality, whereas in Africa and in the Congo in particular, people live through the relationships and the alliances to family, tribes and ancestors.

Vignette 2

I made regular follow-ups, and one of these was of a boy and his elderly mother who had been suspected of catching the virus. They were discharged from the hospital, because any suspicion of having the virus had been ruled out. Even so, the family's members and the villagers were worried and asking questions about their security and health. I accompanied mother and son back to their families and to their village, and we went through counselling sessions to strengthen knowledge about the disease and on the support system.

Indigenous explanations

I had the opportunity to speak with many people in different villages and to patients' families. Their understanding of the epidemic was very much related to an 'ethnic logic'. This logic affirmed that a man is born of the seed of the paternal ancestor, deposited in each womb of a pregnant woman through a chain of seniors. For them the hypothesis was the following: if people are well, in good health (physical and mental) and rich, it is because they are protected and allied with the gods and the ancestors; if instead they are poor and sick, it is because

they didn't take enough care of the ancestors, who revolted against them. Nothing happens by chance; all things have a reason to be and an explanation. As a result of this principle, they thought that the epidemic was due to factors such as:

- Sorcerers, who during their occult practices had to 'eat people' which caused their victims to fall sick and die;
- Debt and disorder within the families, or their tribes;
- Fighting between the Gods and the Spirits: the Charismatic churches and the evangelical sects were fighting witchcraft, and in response, sorcerers had reacted by demonstrating their power through killing many.

Vignette 3

All the customary chiefs, who had power to protect, met with the women of the village. Their aim was to organise a ceremony of protection for the village: 'mutsifu' or 'malombela', during which the assistance of the ancestors is invoked in order to stop the epidemic. Women went from the forest to the village's borders at about 4 am, naked, and carrying wood sticks, singing the intention to barricade the village from the deadly infection.

In fact, in exploring possible reasons for the initial infection with leaders and the population in the area, it appeared that the leader, who was the first to die, had eaten monkey's meat from a monkey found dead in the forest nearby. The risk of infection was heightened by local rituals that required people to touch, wash and dress the dead person. Many started to die soon after the leader did.

Related to these explanations, the following vignette is illustrative. Regarding the origin of the disease, which caused the death of

the leader of a village in the affected area, rumours had it that this leader had been attacked because he had 'lost protection' from ancestors. This meant that the entire village was vulnerable, because the leader is the one who has the power to protect.

Relating indigenous to western healing

People in Kampungu believed that if a disease was known, then traditional healers could find the drugs and the rituals to heal the sick. If, however, the disease was unknown, then it was a reason to take the sick to the hospital. At that stage, their disease fell within the world of modern medicine. There in that world, our role in treating, within an ethno-psychiatric perspective, might be to approach the patient and their families according to the issues that construct and make them as they are: their links, relationships, influences, gods, ancestors, prohibitions, and their active objects (i.e. language, beliefs, and rituals) (Nathan & Stengers, 1995).

According to western medicine, Ebola might have its origins from a virus occurring in monkeys and/or other animals. In a study on trigger events, Pinzon et al. (2004), reported that most of the cases of Ebola outbreaks were suspected to have originated from eating the meat of dead primates. This is also in line with local knowledge, as described in Vignette 3.

As stated above, as there is no treatment available, the only known solution to prevent spreading the infection is by means of an immediate intervention in the affected areas, through prohibiting touching each other. The medical intervention by MSF in 2007 consisted of implementing measures of infection control through protecting and disinfecting the clinic set up. Clinicians, and any other support staff, had to wear

protective clothes over the entire body, so we resembled Martians on Earth! Once outside the clinic, it was mandatory not to touch each other from the beginning till the end of our stay in the mission. Here our fate converged with that of the local people. However, for them the physical and social isolation was much more devastating.

As a professional, I found it was important to explore the ethnic logic, and to negotiate a possible psychosocial support to people in distress, taking into consideration both their own local cultural concepts as well as western psychological concepts. For me personally, this was a very difficult mission: facing serious health risks, watching people die in incredible pain (this was truly dramatic), while the potential for use of psychological methods proved very limited. However, in the end, it was important enough to contain the suffering of the affected community. The ability to also build new knowledge related to the disease, and to navigate between western medical knowledge and local ethnic meanings contributed to the general discourse of psychologically coping with the impact of

an epidemic of a highly contagious and fatal disease.

Acknowledgements

The author is grateful for the editorial support she received from Ton Haans.

References

- Médecins sans Frontières, (personal communication, 2007).
- Nathan, T. & Stengers, I. (1995). *Médecins et sociers*. Paris: Les Empecheurs de penser en rond.
- Pinzon, J.E., Wilson, J.M., Tucker, C.J., Arthur, R., Jahrling, P.B. & Formenty, P. (2004). Trigger events: enviroclimatic coupling of Ebola hemorrhagic fever outbreaks. *American Journal of Tropical Medicine and Hygiene*, 71, 664-674.

*Eva Paglia is a child psychologist, specialised in ethno-psychiatric approaches. She worked for Doctors Without Borders from 2001 until November 2012.
email: evapaglia@yahoo.it*