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GLOBAL MENTAL HEALTH

CONTENT

THERE IS NO HEALTH WITHOUT MENTAL HEALTH

United Nations Secretary-General António Guterres rightly reiterated this simple but powerful message in May 2020, when Covid-19 had been with us for only a few months. Mental health and psychosocial support (MHPSS) are vital for our individual and collective well-being, particularly in these disturbing Covid-19 times. Indeed, MHPSS is a powerful tool to unlock our human resilience and strengthen human capital. This is even more crucial for the most vulnerable people hit by conflict or disaster. The Netherlands therefore strongly advocates recognising the importance of MHPSS for people and communities affected by crisis. We work hard to promote integration of MHPSS into all crisis response from the very beginning. We encourage integrating basic psychosocial skills into the training of every humanitarian worker. Finally, we stress the importance of attending to the psychosocial well-being of humanitarian staff, first responders and volunteers themselves.

These principles are high on the agenda of the MHPSS Reference Group[1], which is part of the Inter-Agency Standing Committee, the longest-standing and highest-level humanitarian coordination forum of the UN. They are also reflected in the December 2019 resolution[2] on MHPSS of the International Red Cross and Red Crescent Movement, which endeavours to provide staff and volunteers with the necessary skills to recognise and respond to psychosocial needs. Staff and volunteers are often rooted in the communities they serve, giving them unique access to these communities as well as knowledge of local context and dynamics. Not only is MHPSS crucial at the individual level, it is also needed and effective at the community level. It helps individuals, families, and communities to release their potential to recover, maintain or regain their resilience and perspective, rebuild social cohesion, resume livelihoods, and foster reconciliation.

MHPSS is at the top of the Netherlands' international development agenda. We are fully committed to an MHPSS-inclusive approach in humanitarian as well as conflict-prevention and peacebuilding efforts. We promote and ensure this through international political and diplomatic efforts, through policy dialogue with our partners, and by supporting a number of initiatives to facilitate MHPSS-inclusive responses in humanitarian and peacebuilding work on the ground.

We therefore very much welcome this special edition of MT*b* dedicated to global MHPSS, and are grateful to its guest editors Rembrant Aarts and Hans Rode for bringing together such a varied pool of authors with varied expertise in the field, both academically and on the ground. This issue of MT*b* is an excellent gateway to disseminate a rich body of knowledge and expertise that is needed so urgently. After all, MHPSS helps to keep our minds and societies at peace.

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'THERE IS NO HEALTH WITHOUT MENTAL HEALTH'

Psychosocial rehabilitation: a global perspective

More than half a billion people worldwide suffer from neuropsychiatric disorders. The vast majority of these individuals live in Africa, Asia and Latin America. Most of these persons lack access to appropriate treatment or care, and many are subject to stigma, discrimination and marginalisation. This adds up to a serious psychological, physical, social and economic burden. Neuropsychiatric disorders can lead to chronic disability and therefore represent an important health issue across the globe.[1] Although there are effective and inexpensive treatments for many neuropsychiatric illnesses, most patients in low- and middle-income countries (LMICs) are deprived of treatment and psychosocial rehabilitation. Ultimately, the burden of mental illness, in terms of suffering and monetary costs, is high for patients and their families.[2]

PSYCHOSOCIAL REHABILITATION

Psychosocial rehabilitation (PSR) is a process of restoring well-being, and social and occupational functioning affected by mental or emotional disorders. Although PSR was long neglected as an intervention, it has gained wider recognition in the last decades. The establishment of the World Association for Psychosocial Rehabilitation (WAPR) in 1986, with the mission to strengthen rehabilitation worldwide, marked an important milestone. Besides mental health professionals, patients, family members and voluntary organisations are also involved in WAPR activities (www.wapr.org). Over the years, PSR has made its way from institutions into communities, taking account of specific regional, historic, economic, social and cultural factors. Our discussion of rehabilitation in this article will refer primarily to patients with schizophrenia, since this group forms more than half of patients with severe mental illness undergoing long-term hospital care.

PSYCHOSOCIAL REHABILITATION IN LMICS

In most LMICs, mental illness carries a stigma that is just as debilitating as in developed countries. The labelling of an individual as 'mentally ill' is associated with important social consequences within the community and among relatives, friends, neighbours and employers, and this hinders the process of recovery. Because of non-existent or very rudimentary health insurance and social welfare, individuals with mental illness in LMICs are often economically dependent on their families. When doing PSR, one has to be aware of the local system and other conditions, and not necessarily assume support from intact extended families. In many cases, growing urbanisation in developing countries means that the extended family system is fast disappearing.[3] For at least 80% of rural inhabitants in LMICs, traditional healers are the main source of help for people with mental disorders.[2] Based on our own clinical experience and observations in LMICs, patients with severe neuropsychiatric disorders do not improve by resorting only to traditional treatment options; they usually need neuroleptic, antidepressant or antiepileptic medication.

COUNTRY-SPECIFIC EXAMPLES

The first attempt to establish community-oriented treatment and rehabilitation in Africa was in 1954 by Thomas Adeoye Lambo,[4] who developed the Aro Village system in Nigeria. Briefly, Lambo's aim was to integrate the traditional village community with traditional healers and modern psychiatry, by offering patients modern psychiatric care locally, within a familiar social environment. Lambo stressed that the strength of this approach was grounded in the resources available in the village community such as flexibility and tolerance. An important element of this approach was recognition of the therapeutic value of the traditional cults, dances and rituals that played (and to a large extent still play) such a large part in the lives of African people.In rural Ethiopia, only 10% of people with schizophrenia have access to biomedical care, a treatment gap largely due to an inadequate number of mental health specialists.[5] The Gefersa Mental Health Rehabilitation Center near Addis Ababa is the only Ethiopian facility that exclusively provides PSR services for individuals with severe mental disorders. This facility is largely inaccessible to most patients who live hundreds of miles away in rural areas, making the establishment of similar facilities for severely affected patients living in different regions essential through large financial investment for infrastructure development and trained manpower. The promising results of a pilot study of a trained lay workers' community-based rehabilitation intervention for people with schizophrenia present a realistic model of PSR for most patients in LMICs.[6] It is important to note that such models are feasible in LMICs as they do not require expensive infrastructures and can be delivered by trained lay workers.

A successful community-oriented rehabilitation programme for persons with chronic schizophrenia was developed in Malaysia in 1978. It prepares individuals with chronic schizophrenia for gainful employment in the community: in a follow-up analysis seventeen years later, 56% of patients had spent five or more years making their own living in their original community settings.[7]

In India there is a large PSR gap largely due to the shortage of specialist mental health care. Thanks to the involvement of NGOs, there are some outstanding examples of PSR in India such as Jyothi Nivas in Kerala. Besides good PSR, it provides innovative anti-stigma campaigns for the surrounding communities. Another successful PSR programme is Chittadhama, a rehabilitation and residential centre for homeless persons with mental illness, in the state of Karnataka.[8]

Many of the issues raised above are not confined to LMICs and may, to some extent, apply to high-income countries as well. In 2017, Drake wrote, 'The central problem, however, is lack of access to high-quality services, even in the wealthiest countries. In the USA, for example, fewer than 5% of people with serious psychiatric disorders can access evidence-based psychiatric rehabilitation.'[9] Bond observed that 'while the USA has led the way in developing, researching and disseminating evidence-based psychiatric rehabilitation services around the world, the quality of mental health treatment and rehabilitation services in the USA lags behind services in many other industrialised nations.'[10] Thus, we need to be aware that research itself does not necessarily guarantee implementation of good PSR services. It requires appropriate policies and political will to provide evidence-based PSR to those who need it. In fact, there are many creative PSR programmes throughout the globe, but there is a scarcity of data to support their efficacy; this implies that there is scope for research on the short- and long-term outcomes of such PSR programmes.

Innovative approaches such as 'supported employment' for people with severe mental illness are available in Europe. Supported employment is a form of PSR wherein individuals recovered from mental illness are assisted to obtain and maintain a job. Even in Germany, where the unemployment rate is low, the chances of a person who suffers from a severe psychiatric disorder finding suitable employment are slim. This prompted the founding of a social firm, the Irseer Kreis Versand, in 1989 to provide protected job opportunities for persons recovered from mental illness. This mail order company started with a staff of seven, five of whom had recovered from a psychiatric disorder.[11] Today (2020), the company's success can be measured by the fact that its workforce comprises 66 persons, fifty of whom are individuals recovered from a psychiatric disorder.

CONCLUSION

Psychosocial rehabilitation aiming at reintegrating persons with chronic mental illness into the community, whether in low-, middle- or high-income countries, is an essential component of mental health care. Any efforts towards improvement of PSR services need to address stigma and discrimination against psychiatric patients since these will influence the implementation, reception and ultimate success of PSR programmes.

Based on the authors' personal experience, the following conditions must be met for the success of psychosocial rehabilitation in any setting:

1. A positive attitude towards the chronic patient
2. Hope that a positive outcome can be achieved
3. A rehabilitative infrastructure
4. Rehabilitation that match the wishes and abilities of the individual patient
5. Acceptance that psychopathology per se does not hinder rehabilitation
6. Providing neuroleptic medication where necessary and bearing in mind that this in itself in not sufficient for patients' recovery
7. Recruitment of an interested and motivated staff
8. Due consideration of the context including local culture, economy, health care system
9. Patience and perseverance
10. Continued efforts to demonstrate to administrators, politicians, and even psychiatrists that psychosocial rehabilitation works effectively to the advantage of patients, their families and community in general

Sadly, the current Covid-19 pandemic adds major challenges for the proper care of people with chronic diseases, including neuropsychiatric illnesses.

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Collaboration between traditional healers and psychiatrists to improve care for people with psychotic disorders

Across the globe, people with psychotic disorders remain at high risk of being untreated, neglected and stigmatised. Worldwide, around 21 million people are affected with schizophrenia, the most severe psychotic disorder.[1] The illness has an average global lifetime prevalence of 0.7%.[2] The global burden of schizophrenia alone accounts for 1.7% of all years lived with disabilities.[1] People with a diagnosis of schizophrenia live on average fifteen years less than the background population.[3] The highest burden is found in low- and middle-income countries (LMICs),[1] where less than a third of people with schizophrenia can access mental health care and their life expectancy is shortest.[4] The course of psychotic disorders is strongly determined by the social, cultural and geographical context. Due to non-medical explanations of mental health problems such as supernatural causes and lack of resources - including limited number of psychiatrists, poor infrastructure, and poor accessibility to the formal health care system - many people with a psychotic disorder in LMICs remain undetected and untreated. It is a key challenge to improve the lives of people with psychotic disorders in low-resource settings and improve adverse social, political and economic conditions. One way to move forward may be to establish collaboration between formal mental health care and the traditional systems of medicine that are in place in most countries.

COLLABORATIVE CARE

Over the past years, the collaboration in mental health between traditional health practitioners (THPs) and the formal health care system has been given attention.[5] Many patients with severe mental health problems, such as psychosis, receive care from THPs. The majority of patients with schizophrenia perceive traditional medicine treatment to be effective for their condition, and high adherence rates to traditional methods have been reported.[6] Recently, a randomized controlled trial was published by Gureje et al. (2020) showing the effectiveness and cost-effectiveness of collaboration between traditional and faith healers and primary health care providers in treating patients with psychotic disorders in Ghana and Nigeria.[7] In a collaborative care model, skills and advantages of THPs are fully acknowledged, and cooperation between traditional health practitioners and the formal health care system exists. Prior to the study, both the primary health care providers and THPs were trained in psychosis, the collaborative care model, and roles and responsibilities. Primary health care providers were involved in medication prescription and psychoeducation, while THPs applied traditional practices such as herbs or rituals. People who received the intervention consisting of collaborative care had better health outcomes than those who received care as usual; they reported less disabilities, a better course of illness, and increased capabilities to adjust to work.[7]

We describe two of our own experiences exploring the role of traditional health practitioners in care for people with psychotic disorders.

EXPERIENCES IN SURINAME

In Suriname, we explored how patients and their family members seek health care and the views and practices of THPs with regard to psychosis. In our first study, we found that the majority of patients with a psychotic disorder and their family members consult a THP, mainly as first line care.[8; unpublished data] Most of the patients and family members reported a supernatural explanation for the cause of psychosis and mentioned it was caused by a spell or the devil. The supernatural causes indicated varied widely and were aligned with patients' culture or religion.[8; unpublished data]

Suriname has a highly centralised health care sector with one psychiatric hospital located in the capital, Paramaribo, and one smaller outpatient clinic in the district Nickerie. THPs in the country include herbalists, Winti healers, Javanese healers, and religious healers such as pandits or imams; they have various ethnocultural backgrounds.[9] As healers, they take on a special communal role as persons of trust and respect - a crucial feature for the detection and follow-up of psychotic episodes. THPs align with the cultural and spiritual ideas people have on the origin and treatment of psychosis, are often located in nearby settings, and are easy to access and consult. By visiting traditional healers as first line care, patients may experience a delay in seeking health care in the formal health care system.[8; unpublished data]

We also explored the potential of strengthening collaborative efforts between formal mental health care and THPs by interviewing traditional health practitioners.[10] Some of the traditional healers said they had a positive attitude towards collaboration, while some were sceptical. The reasons for being sceptical were mainly related to certain thoughts about the biomedical management, different attitudes and explanatory models on psychosis, and the lack of acknowledgement of THPs by medical and governmental bodies in Suriname. Interestingly, some form of referral system to general practitioners existed, although not formalised. This feedback as given by THPs should be transferred to the formal health care system, providing a perspective on traditional practices, and a possible basis for collaboration. In designing our qualitative

study and conducting these interviews, we discovered that health care professionals in the formal system also need to become acquainted with traditional practices and to overcome certain barriers towards the non-formal system.

EXPERIENCES IN SOUTH AFRICA

In rural South Africa, traditional health practitioners and faith healers provide a major part of first line care for health problems. In a resource-limited setting in KwaZulu-Natal, we started building a collaboration with traditional healers. The THPs were educated with case vignettes to identify and refer patients with psychosis to our study team investigating the incidence, early course, and treatment pathways of psychotic disorders in this context.[11] The collaboration was optimised by applying a culturally sensitive approach with support from local traditional as well as professional authorities.

As a first step, meetings were organised with tribal counsellors, followed by a presentation of the study to the senior traditional chief of the region and the traditional council to which THPs are affiliated. As they saw the added value of collaboration for THPs and their communities, a formal memorandum of understanding was signed and contact details of THPs provided. A Community Research Advisory Board was established, providing feedback research procedures in relation to the social and cultural values and beliefs of study participants and the wider community. Finally, semi-structured interviews and multiple focus group meetings with THPs were held. Symptoms of psychosis, help-seeking behaviours of (caregivers of) individuals with symptoms, experience regarding referrals and subsequent treatment outcomes, personal beliefs on causes of mental illness, and treatment practices were extensively discussed. The collaborative approach demanded sufficient time to build mutual trust and acknowledgement of each other's skills and practices. Whereas the worldview of THPs and their recognition of causes of mental health problems (e.g., displeasure of ancestors) differ from a biomedical psychiatric framework, it was possible to discover common ground during focus group meetings and interviews, which allowed for developing a collaborative project of screening and referral by THPs of individuals with suspected psychosis.

CONCLUSION

Since 1991, the World Health Organization has been advocating for proper use of traditional medicine to achieve health for all. More recently they stated that traditional and complementary medicine can contribute significantly to achieve universal health coverage in global mental health.[12, 13] Studies like Gureje et al. (2020) and our own initiatives can contribute to this movement. Our experiences in Suriname and South Africa, which have highly decentralised health care systems, make it clear that extra attention is needed to overcome distance between the THPs and formal health care system. The role of THPs in mental health care cannot be ignored, and lessons learned from previous as well as our own studies deserve attention in designing collaborative care models that align with local infrastructure and health care systems.

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Stigma, schizophrenia, suicide: a global perspective

In old Greek, the word στίγμα (stigma) had the meaning of 'brand, to be branded, to be marked'. Over the ages up till our time it has evolved into a mark of disgrace, associated with a particular circumstance, quality or person. Stigma plays an important role in mental health, as it influences the way psychiatric patients are perceived by the general population and how patients see themselves.[1] It is interesting to see how stigma relates to or interacts with schizophrenia, and suicide. For this reason a PubMed search was conducted in 2018 with the terms 'stigma', 'schizophrenia' and 'suicide'. This resulted in large numbers of published articles: stigma 20,522, schizophrenia 134,032 and suicide 78,827. I will discuss the interaction between these three conditions.*

STIGMA AND HEALTH**

Extensive research has been done on stigma in relation with leprosy and with HIV/Aids, both communicable diseases. Nsaga et al. (2011) found that the more people were affected within the community, the smaller the stigma, present and perceived.[2] This probably means that the 'social stigma' was small. Social or external stigma is different from internal stigma, which eats away at people's self-esteem and self-efficacy. The Jewish woman wearing a yellow star (Figure 1) will initially have suffered from social stigma, but later on this might have evolved into internal stigma, had she been given the time to live.[3,4] Prisoners in orange overalls are stigmatised by those orange overalls, social stigmata, which, depending on the duration of their imprisonment might or might not evolve into self-stigma. Then again, within the prison walls, as in a ghetto, stigma will be less. Research in the field of HIV/AIDS has shown that, because of the already existing social stigma, internal stigma plays an important role resulting in persons hiding the fact that they are infected. Mhode et al. describe another form of stigma: 'anticipated stigma'.[5] In Dar es Salaam, they found that, in order to avoid stigma, persons infected with HIV became secretive and, rather than seeking medical advice, devoted themselves to spirituality. However, if they were able to accept the reality of the situation, they could become proud bearers of the term 'living with HIV', supporting themselves and others in self-help groups[6] - thus, reducing internal stigma and, by opening up to the community as a whole, hopefully reducing social stigma.

Figure 1. Jewish woman (cc- Bundesarchiv).

STIGMA AND SUICIDE

Both social and internal stigma have been associated with suicide and suicide attempts. Every year approximately 100,000 people in the Netherlands attempt to end their lives; in 2019 suicide attempts totalled 1,811. To help people considering suicide and to avert the fatal outcome, a programme was started in 2009 by the late Jan Mokkenstorm. In April and May 2013 alone, 1,732 people contacted 113 Zelfmoordpreventie (Suicide prevention), an emergency telephone number and online service that was initiated just one year after the programme had started. It turned out that 46% of those seeking contact were receiving psychological treatment, and when the content of the chats was analysed, 41% had objectifiable psychiatric symptoms.[7] Surprisingly, more than half the people with suicidal ideations were not receiving psychological treatment, and their suicidal thoughts were not in themselves linked to a manifest psychiatric disorder. It can be assumed that 113 Zelfmoordpreventie has also worked in several ways to reduce stigma. First, due to the anonymity guaranteed to users, the role of internal stigma was reduced. Secondly, spearheading a campaign to bring the problem of suicide into the open also reduced social stigma.

In my initial search, 597 publications addressed both stigma and suicide. Carpiniello and Pina came to the following conclusions: 'self-stigma' develops in a person having committed one or several suicide attempts and in the relatives of this person; 'social stigma' exists in the community towards suicidal persons and in the community towards relatives of those having committed suicide.[8]

Their findings are supported by Moore et al., who found that 'inmates face many hardships once they are released into the community and are being stigmatized. Being an ex-offender is often found to be a major barrier to successful community reintegration.'[9]

STIGMA AND SCHIZOPHRENIA

In my search, 1,065 publications addressed both stigma and schizophrenia. Two of those publications are especially interesting for our purpose. Assefa et al., from Addis Ababa, use 'experienced stigma' and 'internalized stigma' as their parameters.[10] These are comparable to social and internal stigma respectively. In a group of 212 patients, using the diagnosis of schizophrenia via an Amharic version of the Internalized Stigma of Mental Illness (ISMI) scale, they found a 50% to 72% range of internalized stigma. They also found that the level of internalized stigma in patients with schizophrenia was comparable to internal stigma in European patients with schizophrenia.[11] Factors associated with a higher

level of internalized stigma were: rural residence, single marital status, and prominent psychotic symptoms.

In Istanbul, Ücok et al. interviewed 103 stable outpatients with schizophrenia and found that a low level of symptoms correlated with a lower degree of anticipated stigma at school or work.[12] If more pronounced symptoms were present, the opposite was true.

SCHIZOPHRENIA AND SUICIDE

Of the 2014 publications addressing schizophrenia and suicide in my search, I will discuss just one. Cassidy et al. (2018) published a meta-analysis on risk factors for suicidality in patients with schizophrenia. They conclude that 'suicidal ideation' is related with high scores on BDI and HAM-D, a high score on PANSS, and a greater number of psychiatric hospitalizations; 'suicide attempt' is associated with hopelessness, history of depression, history of attempted suicide, family history of psychiatric illness, family history of suicide, being white, and history of addiction; 'suicide' is more frequent with shorter illness length, younger age, and higher IQ.[13]

STIGMA, SCHIZOPHRENIA, AND SUICIDE***

Of all the articles sampled in my search, only 38 addressed stigma and schizophrenia and suicide. From the six publications listed in Table 1 and their main conclusions, one may conclude that, worldwide and across cultures, the interaction between stigma, schizophrenia and suicide is important and significant (Figure 2 and 3).

A paper by Shrivashtava et al. on a study in Toronto sums up the dilemmas health workers face when working with people suffering from schizophrenia.[14] They found that stigma delays treatment seeking, worsens course of burden and outcome, reduces compliance, and increases the risk of relapse.

DISCUSSION

Psychiatrists in their daily work often find that patients with schizophrenia, experiencing stigma and considering suicide, find themselves in a vicious circle. The question arises: where and how can we stop going in circles and reduce dramatic outcomes? We can treat psychosis and we can reduce suicide by addressing the topic candidly with our patients. Stigma however is not always considered during patient consultations. Recognising and discussing stigma can interrupt the vicious circle. This would be in line with the advice of Shrivastava et al, who state that stigma needs to be assessed during routine clinical examination, and subjected to further research in order to develop measurable objective criteria and

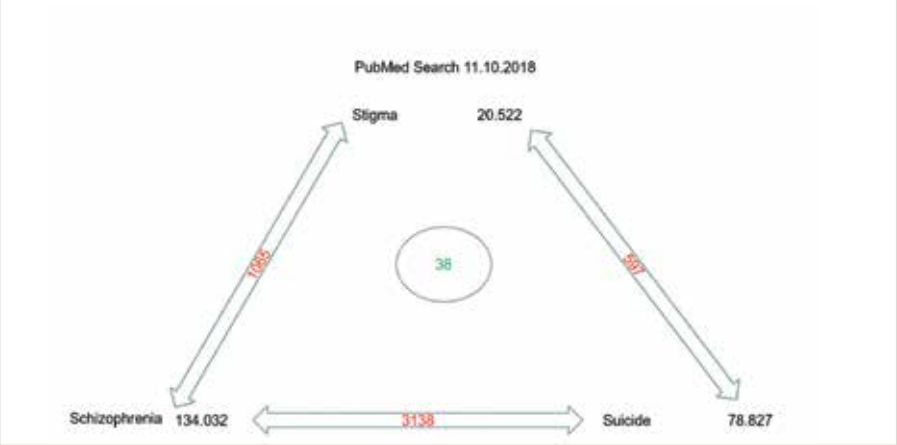

Figure 2. Numbers of publications on stigma, schizophrenia and suicide.

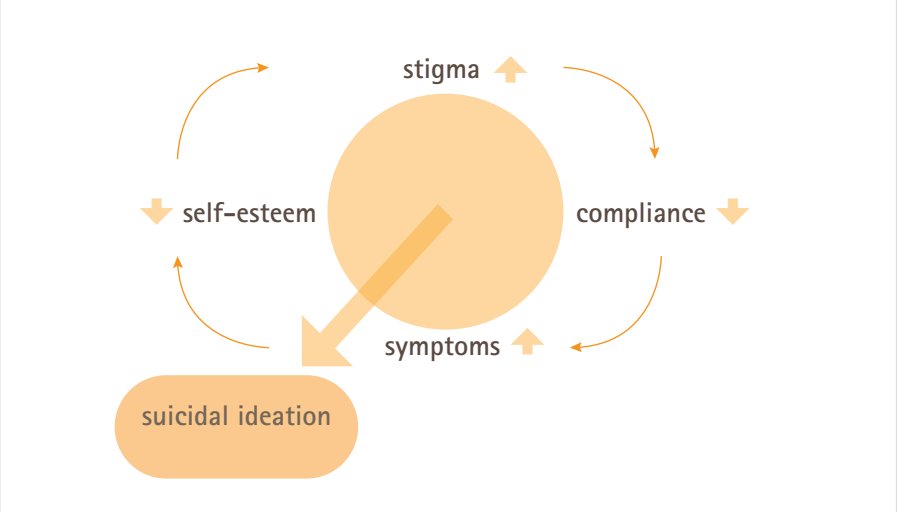

Figure 3. Relationship between increased stigma and suicidal ideation.

Collett N, Pugh K, et al.	United Kingdom	2015
Marked negative self-cognitions and high levels of suicidal ideations in patients with persecutory delusions		
Stip E, Caron J, et al.	Canada	2017
Perceived cognitive dysfunction and stigmatisation contribute to the onset of suicidal ideation		
Yoo, Kim, et al.	South Korea	2015
Low self-esteem closely related to suicidal ideation		
Lien YJ, Chang HA, et al.	Taiwan	2017
Positive correlation between low self-esteem, insight and suicidal attempts		
Touriño R, Acosta FJ, et al.	Spain	2018
Association between internalised stigma, higher hopelessness, depression and higher suicidality		
Sharaf AI, Ossman LH, et al.	Egypt	2012
Internalised stigma and depression independently predicted suicide risk		

Table 1: Publications on stigma and schizophrenia and suicide and their main conclusions.

assess whether treatment can reduce the effects of stigma on patients.[14]

CONCLUSION

In the interest of patients diagnosed with schizophrenia and their relatives, stigma and suicidal thoughts need to be discussed as part of treatment and care. One might ask, 'Where do we go from here; how can we reduce stigma?' A recent systematic review by Clay et al. gives an overview of methods shown to be effective in low- and middle-income countries, including: health education and myth busting by using informal groups, broadcasting, and social media.[15]

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AUTHOR'S REMARKS

* In the literature different forms of stigma are mentioned: social, external, internal, and anticipated stigma, to name just a few. For our purpose the dichotomy between social and internal suffices

** Social stigma is the societal disapproval (or discontent) that a person or group perceives based on particular characteristics, and which some people use to distinguish them from other members of a society. Stigma may then be affixed to such persons, by society at large, as they seem to differ from the mainstream cultural norms

*** BDI and HAM-D are scales to rate depression; PANSS rates psychotic symptoms

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PHOTO NICK FOX (SHUTTERSTOCK)

Mental health and psychosocial support: hidden potential and harm

Towards understanding the unintended and intended social effects of mental health and psychosocial support interventions

In October 2019, Dutch Minister for Foreign Trade and Development Cooperation, Sigrid Kaag, organised the International Conference on Mental Health and Psychosocial Support in Crisis Situations. Together with a coalition of 28 countries and ten organisations, she signed the *Amsterdam Conference Declaration*, which pledges a commitment to 'look for opportunities to draw attention to mental health and psychosocial needs of people affected by emergencies' and 'to integrate and seek opportunities to further scale up mental health and psychosocial support'.[1] This pledge resulted from the growing attention for large unmet mental health needs among people affected by disaster and conflict. Although estimated rates of mental disorder after conflict vary between contexts, a meta-analysis of 'methodologically stronger' surveys displays average prevalence rates of 15-20% for depression and post-traumatic stress disorder.[2] In contrast, only 0.3% of all development assistance for health was dedicated to mental health between 2006 and 2016.[3]

At the conference, an important call for action was made to increase the available budget for mental health and psychosocial support (MHPSS). MHPSS is the catch-all term for various interventions addressing mental health needs, ranging from psychotherapy to music lessons. Policy makers and practitioners increasingly consider MHPSS to be a crucial element of humanitarian aid. They further expect MHPSS to have positive effects on political and socioeconomic goals such as 'poverty reduction, peacebuilding, addressing gender-based violence and [the] reconstruction of affected areas and economies'.[4] This article argues that the pledged commitment and call for more funding should go hand-in-hand with an increased investment in (academic) knowledge production on the functioning of MHPSS, as we currently lack a comprehensive understanding of these interventions, and in particular of their positive (potential) and negative (harmful) longer-term effects.

UNCOVERING UNINTENDED EFFECTS

Both practitioners and academics have warned of the possible unintentional harm MHPSS interventions may cause to their recipients.[5] Following Shah, harm can be a direct consequence of MHPSS interventions not being designed in a culturally appropriate manner, resulting in several negative consequences such as harm to psychological wellbeing and erosion of community's trust in MHPSS.[6] For example, he described the case of combatants in Sub-Saharan Africa for whom conventional therapy would increase distress, as they believe talking about the people they killed invites angry spirits.[6] Adverse effects may also follow from the interplay between context and intervention, when sources of stress are left unaddressed and interventions subsequently run the risk of being negatively experienced as 'irrelevant or imposed'.[7] According to Miller and Rasmussen, available data suggests that 'daily stressors' (social and material conditions such as poverty, family violence, unsafe housing, and social isolation) cause mental health problems, and therefore should be a priority in MHPSS.[8] If focus is limited to individual psychological trauma resulting from conflict or other humanitarian emergencies, the collective experience is overlooked and people's capacity to recover is not strengthened.[7] Avoiding harm is a central point of attention within the internationally recognised *IASC Guidelines on mental health and psychosocial support in emergency settings*, which state that 'the potential for causing harm as an unintended, but nonetheless real, consequence must be considered and weighed from the outset' in all humanitarian interventions.[9]

Evaluations of interventions in the field of international cooperation, however, often fail to analyse unintended effects, and are therefore in need of more appropriate methodologies, as addressed by Koch and Schulpen in the article *Introduction to the special issue 'unintended effects of international cooperation'*.[10] Most evaluations exclusively focus on intended objectives and have a short-term design, thereby neglecting unintended effects, especially those which may only arise after a longer period of time. While the intended direct effects of MHPSS interventions have been rigorously assessed by randomised control trials (RCTs), this method is known for its risk of overlooking unanticipated outcomes.[11] Yet, analysing unintended effects is necessary to be able to plan the most adequate interventions and to mitigate the risk of doing harm. Unintended effects can thus be negative, causing harm, but they can also be positive, creating additional, unexpected benefits, or even neutral.[12] Positive unintended effects are particularly underrepresented in the literature,[10] which makes it more difficult to capitalise on them. So there are lessons to be learned that can help further improve MHPSS.

WHAT ARE THE KNOWLEDGE GAPS?

Our research team from Radboud University conducted a literature search between 1 July 2020 and 20 September 2020 to get a first impression of which unintended effects of MHPSS interventions have been described in academic literature between 2011 and 2019.[13] Based on the reference lists of seven recently published systematic reviews on MHPSS interventions in man-made

and natural humanitarian emergency settings, our search revealed that only twelve out of the 134 studies reported unintended effects. Out of these twelve studies, eleven described an unanticipated negative change in symptoms related to mental health, and only one study reported a social unintended effect. The studies included in our literature search had a strong focus on direct and intended effects, namely the possible improvement of mental health. These findings suggest that unintended effects, which transcend the psychological and individual, are being overlooked. The twelve unintended effects described above were all found in quantitative studies, which is likely related to the fact that most studies in the reference lists were quantitative (111 out of 134). Adding a qualitative component may help detect other types of unintended effects, through inductive analysis of MHPSS interventions.[11]

Furthermore, Blanchet et al. have shown in their systematic review that most of the attention is aimed at psychological interventions, and that the evidence-base of psychosocial interventions is weaker, although this type of intervention is most commonly practised.[14] Since many of the claims made to spur investments in MHPSS point to the social outcomes of these psychosocial interventions, it is pivotal to research if these are true.

Finally, the evaluations of the included studies all considered short-term effects only, and were conducted between two weeks and eight months after the intervention took place. In this regard, we lack knowledge about the long-term (socioeconomic) impact of MHPSS interventions for displaced persons and the larger community.

WAYS FORWARD

A new research approach is required to reach a comprehensive understanding of the unintended and intended social effects of MHPSS. First, in order to make claims about these effects, it is essential to follow participants in MHPSS interventions over a longer period of time. A longitudinal and mixed-method research design will allow us to come to a more encompassing understanding of the (unintended) consequences for people who have participated in a MHPSS intervention, such as expanding a social network or finding a job. Studying these long-term and social effects requires a multi-disciplinary approach combining insights from psychology, anthropology and sociology.

Second, participants in MHPSS are often forcibly displaced as a result of humanitarian crises. They therefore move between places, and some may resettle to a new country. Research should thus be carried out in multiple geographical contexts to follow people who have participated in (perhaps multiple) MHPSS interventions. This will allow us to investigate the extent to which effects depend on contextual factors (e.g. the living conditions of a host country), and to analyse if MHPSS has effects on migration trajectories and integration.

Third, special attention should be given to psychosocial and multidomain interventions. These interventions target mental health and social life domains simultaneously, such as safety and education at the family or community level. The evidence base is currently weaker for these interventions compared to psychological interventions. Psychosocial and multidomain interventions do however offer a possible pathway to overcome the negative effects of overlooking structural problems and capitalise on positive effects of mental health improvement.

Together, these three steps form the basis of our research team's new approach, and can contribute to understanding MHPSS more comprehensively.

CONCLUSION

There is a need to deepen our understanding of the intended and unintended social effects of MHPSS interventions. This requires a long-term, multi-disciplinary approach, carried out in multiple contexts and preferably focusing on psychosocial and multidomain interventions. Insights gained can contribute to an advanced, more encompassing evaluation framework. Now is the right time to jump on the bandwagon, as MHPSS is receiving increased attention and funding. There is great hidden potential in MHPSS to heal, but also to do harm. This is why its effects, both intended and unintended, positive and negative, deserve a more critical evaluation, and this requires investment from the academic and policy community.

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References and background information about literature on page 18.

Mental health care in Cambodia: history, status and a personal report

For about forty years, the first author (JvH) has been involved in the training and education of various mental health professionals in the Netherlands, South Africa, Gambia, Russia, China, Sri Lanka, and Myanmar. Through the Transcultural Psychosocial Organization (TPO Cambodia), he became affiliated with the Khmer-Soviet Friendship Hospital (KSFH) in Phnom Penh, Cambodia, since 2015. HealthNet TPO is a global aid agency with roots and its headquarters in the Netherlands, which has been working on restoring and strengthening health care systems in areas disrupted by war or disaster since 1992. The organisation is the result of a merger (in 2005) of the former TPO International and HealthNet. TPO Cambodia was established in 1995 as a branch of the former TPO International and registered in Cambodia as a not-for-profit NGO in 2010.

CAMBODIA AND ITS HISTORY

Nowadays Cambodia is one of the poorest countries in South-East Asia. However, it is a country with a glorious history between the 9th and the 14th century when the Khmer Empire covered a large part of the region, including Thailand, Laos, Vietnam and Malaysia. Thereafter, the country experienced turbulent periods of occupation, civil war, and the devastating regime of the Khmer Rouge led by Pol Pot. During this regime (1975-1979), over two million people were killed or died due to starvation and disease. The subsequent years brought misery until the Paris Peace Agreements of 1991, which ended the Cambodian-Vietnamese war.

MENTAL HEALTH CARE WORKFORCE AFTER THE PARIS PEACE AGREEMENTS (1991)

At that time, the public health system of Cambodia was demolished, and only a few medical doctors and other health workers were still active. Quoting Daniel Savin: 'In 1979, none of 43 surviving medical doctors in Cambodia were psychiatrists.'[1] Many higher educated people were killed in the name of the revolution of the Pol Pot regime.

Immediately after the peace agreements, the Cambodian government formed international partnerships with the International Organization for Migration (IOM) and the University of Oslo in cooperation with Harvard University for the training of 26 psychiatrists and 40-45 psychiatric nurses. However, since the original training programmes ended, there has been no regular training of psychiatric nurses.[2] Regarding medical specialists, the Cambodian University of Health Sciences took over the three-year psychiatry residency training programme.

PRESENT STATUS OF MENTAL HEALTH CARE

Currently, Cambodia has about 16 million inhabitants. The present status of mental health care in Cambodia is reflected in the total number of mental health specialists. Cambodia has about sixty psychiatrists,[3] which is fifty times less (calculated per 100,000 inhabitants) than the Netherlands.
In addition, there are currently about 200 psychologists working in Cambodia as compared to 16,000 in the Netherlands.[4] There are also only a few government mental health clinics operating, predominantly located in urban centres. Finally, the total number of psychiatric in-patient beds is below twenty. Since 2010, there have been strategic plans to improve mental health care in the country, particularly to increase the number of specialised clinics and enhance resources. However, in 2016, it was clear that the system was still ill-equipped and provided only limited services. Funding remained too low, resources too limited, and training initiatives and projects frequently relied on external funding.[5,6] Information on the training of psychiatrists and psychologists is presented in Table 1.

TPO CAMBODIA AND OUR VISITS

TPO International engaged in the promotion of mental health in war and conflict zones worldwide, and started a community based mental health programme in Cambodia in 1995, with the aim of identification, prevention and management of psychosocial problems.

PSYCHIATRIC TRAINING	PSYCHOLOGIST TRAINING
6 yrs Medical + 3 yrs specialisation at University of Health Sciences	4 years bachelor + 2 yrs master at Royal University of Phnom Penh
Full time training No salary (need for wealthy parents)	Training only in the weekend Work for their living during the week
Mainly biological framework and treatments	Different psychological frameworks used
Work in state hospitals (600 USD monthly) + private pactice	Work in Private practices + counseling hospitals

Table 1. Summary of training of psychiatrists and psychologists in Cambodia.

In the beginning, a core group was formed by Willem van de Put and Maurice Eisenbruch,[7] which consisted of Cambodians who were offered culturally appropriate and relevant training, monitoring and supervision - based on the daily experience of assessing existing problems and identifying realistic solutions in the field of psychosocial problems in the community. For example, in rural villages patients with psychotic disorders were of most concern and therefore the staff of local hospitals were trained in basic mental health care to cope with these patients. Since 2000, the project has continued its activities as the independent TPO Cambodia.[8] Nowadays, TPO Cambodia is a relatively large Cambodian NGO, which plays a trendsetting and educational role in mental health care developments. They realise outpatient and social psychiatric care, particularly in rural areas, and broadly provide information in the field of mental health.

The first author (JvH) has participated in TPO Cambodia's capacity building programme since 2015, both in the capital Phnom Penh as well as in rural areas. The capacity building programme consists of lecturing, training small groups of psychiatrists, residents, psychologists and students on main psychiatric diseases, diagnostic procedures through roleplaying, and communication with patients.

The multi-disciplinary programme operation and evaluation provided the following insights concerning mental health care practice. Patient problems in various areas of life are evaluated and treated individually, without considering the mutual relationships between psychosocial and medical problems. In other words, it is not common practice to link the dynamics of the psychosocial system and the dynamics of the interpersonal communication with the stress put on the patient and the mental decompensation. Therefore, a broader understanding should be developed of the pathogenesis of the psychiatric disorder in a specific patient. We also missed the contribution of patient organisations in the psychoeducation and sharing of common problems of patients. There seems to be little coherence in visions and working models of psychosocial workers, psychologists and psychiatrists. This appeared especially relevant in the treatment of therapy-resistant patients. Therefore, in the programme, we performed a multilevel problem analysis, with a biopsychosocial model for better understanding the problems that the patients and their families are confronted with. On the basis of this analysis, therapeutic interventions were proposed. In addition to system interventions, psychotherapeutic and pharmacological treatments of these patients were discussed. In Phnom Penh, many thousands of people are treated with antidepressants, but many of them are treatment resistant and require other therapy. For these patients, we introduced electroconvulsive therapy as a potential treatment, discussed its indication assessment, and also performed training on its application.

Finally, in the rural areas we provided training to various TPO Cambodia teams of mental health workers and employees of local hospitals, in particular on how to conduct a psychiatric interview and topics like depression, schizophrenia, and addiction. Through our conversations, we obtained insight into the great constraints of mental health care in these areas.

Training on use of ECT apparatus

EXPERIENCE-DRIVEN RECOMMENDATIONS TO ADAPT MENTAL HEALTH IN CAMBODIA

Based on the experiences of the first two authors (JvH, SR) with co-workers and also the conversations with leading people in the government, hospitals and NGO's, we made the following recommendations for improvement in mental health care in Cambodia, which we will incorporate in the development of our future programmes.

- Promote multidisciplinary cooperation, e.g. in the KSFH also psychologists and social workers could do a lot of good work, while they are absent now. Furthermore, experts from ministries, hospital managements, and assurance companies, practitioners, and traditional healers could focus more on joint attention and cooperation.
- Psychotherapy could be used also in a much more integrated manner. In this respect, it would be advisable to integrate the education of psychologists and psychiatrists in order to improve cooperation.
- Psychiatry could benefit from more frequent use of second generation psychotropics, like lithium and clozapine, especially for treatment of therapy-resistant

patients. However, in that case, laboratory facilities have to be improved to enable measurement of lithium plasma levels, measurement of thrombocytes and further blood picture, and measurement of drug plasma levels.
- Patient organisations could be initiated or strengthened, e.g. Alcoholics Anonymous could be invited to settle in the cities as well as in rural areas.
- The highly motivated new generation of psychiatrists and psychologists should be facilitated in further extending their knowledge, e.g. by attendance of conferences or summer schools (also abroad).
- Under the guidance of governmental institutions and local NGOs, consultation and education by mental health care professionals from abroad could make a difference. The recent initiative of the department of transcultural psychiatry of the Netherlands Psychiatry Association to establish a group of psychiatrists interested in global mental health could also support projects in Cambodia with required expertise and means.

These recommendations were positively received by TPO Cambodia and the colleagues at KSFH. In addition to internal Cambodian considerations, these ideas convinced AROM, the recently initiated platform of psychiatrists and psychologists, to prioritise the cooperation between both disciplines.

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CAMBODIA HAS ABOUT SIXTY PSYCHIATRISTS, WHICH IS FIFTY TIMES LESS (CALCULATED PER 100,000 INHABITANTS) THAN THE NETHERLANDS

THERE ARE ABOUT 200 PSYCHOLOGISTS WORKING IN CAMBODIA AS COMPARED TO 16,000 IN THE NETHERLANDS

Art aimed at understanding the mentally ill

The fear of going crazy or losing oneself completely is one of the greatest fears we know. One in four people will face mental difficulties in their lifetime. If it is not you, it is one of your friends, family members or colleagues who suffers from a period of mental illness. Unfortunately, this does not lead to the understanding, solidarity and financial support we have come to know for other diseases such as cancer or aids. Psychiatric patients are often stigmatised and the field of psychiatry often suffers from financial limitations. As a result, patients refrain from seeking treatment, or treatment is not accessible at all. Poor access to mental and physical health care causes a reduced life expectancy, exclusion from higher education and employment, increased risk of contact with the criminal justice system, victimisation, poverty and homelessness.[1] According to stigma expert Graham Thornicroft, the most widely used and effective intervention to target stigmatisation in psychiatry is to improve social contact between mentally healthy and ill people.

THE BEAUTIFUL DISTRESS FOUNDATION

In 2014, the Beautiful Distress foundation was started with a mission to reduce psychiatric stigma through art projects. Even though mental illness often evokes negative emotions, it is also a source of creativity. By bringing these two worlds together, Beautiful Distress wishes to validate the world and experiences of the mentally ill.[2]

Beautiful Distress organises residencies in different countries. The concept of the residency is simple: the cooperating hospital provides an apartment and a studio within the hospital for a period of three months. The resident artist comes into contact with the patients and staff on various wards to do research and practice their art. At the end of the residency, the artist has produced a body of work, which is first shown in the hospital and later in various Beautiful Distress activities. Art can tell the stories of psychiatry to a large audience, which does not come in contact with mental illness or psychiatry on a daily basis. In contrast to earlier initiatives such as Het Vijfde Seizoen (The Fifth Season), the residencies were not focused on the artistic development of the artist but on the implications their work has for the patient and society. To promote social interaction around their work, all works are exhibited in closing meetings and symposia where a broad audience is invited, including policymakers, patients and their families, artists, health care practitioners, and the general public.

Photo by Annaleen Louwes, from series: Black and white and (some) kind of blue or I only want to be happy

THE RESIDENCIES

Over the past years, various Dutch and international artists have entered the residency programme at Kings County Hospital in New York City and Fukuroda Hospital in Daigo, Japan. The cultural differences and different perceptions of psychological vulnerabilities are the start of an international exchange of images, ideas and solutions.

Kings County Hospital is a huge public mental health hospital situated in a poor part of Brooklyn, New York City. The hospital is in a crowded neighbourhood with mostly poor people with various ethnical backgrounds experiencing difficulties in surviving in the city. This is in striking contrast to Fukuroda Hospital, about 160 kilometres from Tokyo. In Japan, having a mental illness is hard and especially shameful. As a result, patients are not seen in public. The town Daigo is a small, aging city where most of the young people have left. As Fukuroda Hospital provides patients with education and teaches them skills, patients often continue living in the town. As a result, the town is becoming economically dependent on a marginalised group.

All residencies share the following themes. According to a systematic review by Leamy et al., the determinants for personal recovery are: connectedness, hope and optimism about the future, identity, meaning in life, and empowerment.[3]

As an example, the first residency at Kings County Hospital focused on the first theme, connectedness. Annaleen Louwes was the first photographer and white female in a mixed group of patients. It took some time for her to gain the trust of the patients. The gap between her and the patients became smaller when she decided to reverse her photos in a negative colour scheme. The result showed that all persons had the same blue-toned skin colour. From that moment on, everybody wanted to be in the project, which resulted in an exhibition and a book titled: *Black and white and (some) kind of blue or I only want to be happy.*[5]

SOCIAL INTERACTION

Following a residency, the artworks are exhibited in the Beautiful Distress House in Amsterdam or elsewhere. Posters are hung throughout the city to reach a broad audience. In addition, a series of meetings called 'madness meets art' is held where a broad audience including policymakers

and the mental health institutes are present. Our aim is to present smart and clear recommendations in order to reduce stigma in psychiatry.

As a framework we use the publication of Laemy et al. For example, Jan Hoek created a project *Mental superpowers* in New York City.[6] He asked people to visualise their demons and delusions with a twist: turn your demon into a creature which gives you power. Together with the patients, he searched for props and took pictures. Vulnerability turned into strength. Identity and empowerment are the major themes. We repeated this in a mental hospital in Amsterdam and are now in the process of collecting the experiences. We will hold discussions with our partners on how to convert those experiences into recommendations that will really combat prejudices against people with psychological vulnerabilities.

FUTURE OUTLOOK

Beautiful Distress is an international growing foundation with a mission to fight psychiatric stigma through art projects. Although current residencies are on hold because of the Covid-19 pandemic, exhibitions and meetings are still planned. For 2021, an exhibition and education programme will start on the theme Psychiatry, sexuality and power. Not only Dutch artists, but also artists from Syria, Egypt, Armenia and Chile will reflect together on this theme. The foundation keeps growing within the Netherlands and also abroad. Especially in countries where access to mental health care is limited, storytelling through art, literature, music or theatre can be an accessible way to reduce stigmatisation and clear the path to better mental health.

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Photo by Jan Hoek, from: Mental superpowers, Exhibition Mentrum Amsterdam 2018

Anxiety disorder in Accra, Ghana

Usually you see a Consult Online case report in MT*b*. This time we had wanted to present a case report that relates to the theme of this edition, but unfortunately we did not have any at present. We take this opportunity to request you to submit mental health questions to our enthusiastic Consult Online panel as well. For now we present you a case from Ghana, written by Mohammed Salim Sulley Wangabi, a clinical psychologist, who presents his insights in the mental health care sector in West Africa.

SETTING

This case was seen in a modern regional hospital in Accra, the capital of Ghana, with 620 bed capacity and a variety of specialties including a modest but expanding clinical psychology department.

BACKGROUND

In Ghana, the estimated prevalence of mental disorders is 13% of the adult population.[1] These disorders present in a variety of forms and require various forms of care which could be either pharmacological or non-pharmacological. The mental health sector in Ghana depends to a large extent on pharmacological methods of managing mental illness due to widespread shortages of qualified personnel and resources for psychosocial therapies and rehabilitation. There is also the issue of stigmatisation and superstition which is being grappled with. Mental disorders are prevalent but various factors, including financial capacity and lack of insight, have prevented the urgent management of depression and anxiety, amongst others, until they become severe, requiring pharmacological interventions. The Greater Accra Regional Hospital (Ridge) offers many health care services that promote the health and general well-being of Ghanaians. Notable among these services are the mental health services. The Clinical Psychology Centre is a professional and client-oriented department of the hospital that offers services such as assessments, evaluation and diagnosing of patients with psychological disorders, provision of appropriate therapeutic interventions, reviewing them after psychological intervention, or referring patients whose conditions call for further management and specialised care to other specialist professionals. In addition, the Clinical Psychology Centre provides education on psychological and mental health topics such as stress, anxiety and depression.

CASE BACKGROUND

A 44-year old female business owner came to the emergency ward with a sudden onset of breathlessness. She had a medical history of hypertension, for which amlodipine was started one month previously. Now the patient complains about breathlessness at rest during the day, which worsens at night. She presented with feelings of numbness, cold at the extremities and hot flashes. Additionally, she reported some physiological discomforts such as headaches and uneasiness as well as inability to sit or lie down comfortably. The patient expressed worries that she might be experiencing symptoms of stroke, which made her scared as a stroke situation could render her incapable of taking care of her children. After initial assessment and monitoring, she was referred to the clinical psychologist for further management as all test results were negative. A mental state examination (MSE) indicated a patient who appeared dull and lethargic, well orientated to place, in person and time. In addition, the patient had poor insight into her hypertensive diagnosis. Her thought process was consistent and logical, but her thought content was fear of incapacitation from a stroke, which started over a month ago when she was put on anti-hypertensive medication. The patient was initially accommodating but seemed sad. She started losing interest in the course of the session, as she seemed in pain or discomfort, and was unwilling to say what was wrong or how she was feeling at that moment. She reported sleeplessness, poor appetite, and palpitations that commenced three weeks previously. The patient is a mother of two and living with her children at a rented apartment. She reported spiritual reasons that were stifling her business as well as causing her medical conditions. She has a secondary education, and sessions were done in English with periodic switches to Ga, her local dialect.

ASSESSMENT AND DIAGNOSIS

After initial consultation, a provisional diagnosis of anxiety was made. The patient was taken through some basic relaxation techniques to provide some form of relief. Furthermore, she was assessed using the Hospital Anxiety and Depression Scale (HADS). Her scores were high on anxiety and low on depression, indicating a significant anxious thought pattern, feeling and behaviour. The patient was diagnosed with anxiety disorder and psychotherapeutic interventions were started.

TREATMENT

The patient was taken through the following therapies: progressive muscle relaxation to reduce uneasiness and

facilitate sleep; cognitive restructuring to replace maladaptive thought patterns precipitating her anxious feelings; insight therapy to provide understanding of her conditions and the associated symptoms, and coping techniques to manage her behavioural changes due to her current diagnosis. A week after the initial intervention the patient returned to explore its effectiveness. She seemed to be more relaxed and less worried about her situation. Finally, she went through six sessions of cognitive behaviour therapy and reported an improvement in her thought patterns and emotions, and was feeling hopeful to proceed with her life activities. A post-therapy HADS assessment indicated an insignificant level of anxiety and depression as reported by the patient.

CONCLUSION

The Clinical Psychology Centre still faces teething problems but, as in this case, can provide significant psychological help for a wide range of people with diverse mental health challenges. The centre also provides training and supervision for both local and international students to prepare them in caring for people with mental health disorders. All these activities aim to ensure a mentally healthy society with insight and self-awareness. As this case demonstrates, awareness and attention to mental health problems, resulting in a proper diagnosis and adequate treatment, can significantly improve the health of members of society.

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Continuation of the article on Mental health and psychosocial support by Tessa Ubels (on p10–11)

BACKGROUND INFORMATION

The literature search was conducted by Vy Trân Nhât between 1 July 2020 and 20 September 2020. The seven systematic reviews of MHPSS interventions which were searched, are recently published, between 2011 and 2019, and focus on studies in man-made and natural humanitarian emergency settings. To filter the studies in the seven reference lists, the following eligibility criteria were used: studies published after and including 1980, studies published in English, both quantitative and qualitative studies, both man-made and natural humanitarian emergency settings, all types of MHPSS interventions, interventions targeting both adults and/or children and young people (CYP). 137 studies from the reference lists were found eligible, however, two studies were different samples presented in a separate third study, and one PhD dissertation was not accessible. 134 studies were therefore ultimately included. Titles, abstracts and texts were scanned on the basis of a number of search terms (see table).

Studies which did not describe unintended effects and did not have any relevant keyword hits were excluded, leaving 23 studies. After reading the remaining articles in detail, the studies which only reported a lack of intended effects were excluded. In the end, twelve studies were found to report unintended effects. The seven systematic reviews and twelve included studies are available at request.

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Een goede geest bestaat niet

By Amy Besamusca-Ekelschot
Uitgeverij Mik Schots
ISBN: 978-90-822310-1-4
NUR: 301
2018, 274 pages
Language: Dutch
Price: 20 euros, to support the work of the NGO Kennis zonder Grenzen (Knowledge without Borders), www.kenniszondergrenzen.nl

When I asked my colleagues in the mental health sector what they knew about the Rwandan genocide, the movie *Hotel Rwanda* came up most. This movie is based on the true story of a - according to the movie - brave hotel manager of Hôtel des Mille Collines in Kigali, who was able to protect around 1,200 Tutsis from being slaughtered. The movie ends with the reunion of the main characters in a safe place outside Rwanda, and it seems they are likely to live happily ever after. The book *Een goede geest bestaat niet* (A good spirit does not exist) shows a different side of the Rwandan genocide.

The book follows the true story of Victor, an ordinary young man with a Hutu father and a Tutsi mother. At the start of the war, he is not considered Hutu and has to flee on foot to neighbouring Democratic Republic of the Congo (DRC). During the escape he witnesses horrible murders and deaths due to disease, hunger, thirst and fatigue. No matter how hard he tries, he can't avoid the smell of the dead bodies. His situation is bleak: he could be killed, he sees no future for himself, and he comes close to dying a number of times.

He manages to escape Rwanda, and from DRC he moves on to Belgium, where he suffers a brief period of depression. But he recovers without any remaining severe psychiatric symptoms. He integrates well into Belgian society, gets married, and becomes a psychiatric nurse. Frequently, he talks about his past with friends and even in larger groups, but he makes sure to leave out the horrific details. When he is by himself, he often thinks back to what happened in Rwanda and feels guilty towards those who didn't survive such as his own mother.

One of the most interesting aspects of the story is that despite all the trauma he endured, Victor is not suffering from typical post-traumatic stress disorder (PTSD), which has a particular pattern of symptoms such as flashbacks, avoidance of trauma related triggers, nightmares, and hyperarousal. Victor feels he doesn't have the right to feel bad about what happened, because he was one of the lucky ones. He got the chance to start a new life, so he suppresses most of his feelings and does not seek any professional help to process his memories. He sends money back to family members who remained behind, which leads to confrontations with his wife. He frequently fears he may be hunted by the bad spirits of his ancestors and family and friends who didn't make it.

Having lived in Belgium for over fifteen years, Victor returns to Rwanda to work as a psychiatric nurse for a year. Being there physically, his memories intensify and he starts experiencing nightmares and flashbacks. He keeps this to himself, still feeling that others suffered much more. He eventually finds some peace of mind by asking the spirits for forgiveness. At the end of the book, Victor returns to Belgium. The importance of including cultural aspects is emphasised by several of his Belgian friends, with whom he discusses how non-governmental organisations that received funding to help Rwanda use their Westernised explanation model for trauma, leaving out cultural aspects such as the importance of keeping good relationships with the spirits.

I would strongly recommend reading this book because I think this story should be heard. Most of the people I gave the book to so far found it hard to get through the parts where the traumatic experiences are described because of the gruesome details, but also found it important that this side of the genocide is highlighted. For doctors working with psychiatric patients, it's hard to picture what the people of Rwanda have been through because it's so different from reality as we know it.

What this book mostly demonstrates is the various ways psychiatric symptoms can manifest themselves in people with a different cultural background from our own. Doctors working with psychiatric patients are trained to diagnose and treat purely on PTSD as described in the *Diagnostic and Statistical Manual of mental disorders, fifth edition, DSM-5*. It would therefore be of great value to pay more attention to the cultural expression of psychiatric symptoms in global mental health training and most of all, to remain curious and ask open explorative questions to each of our individual patients.

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NVTG
online symposium
Friday 22 January 2021
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mind matters

MORE GLOBAL MENTAL HEALTH in the upcoming NVTG symposium and webinar

Interested in learning more about, and discussing current issues in global mental health? Please be invited to join the following ONLINE NVTG events:

WEBINAR on **Tuesday 19th of January from 19.30 to 21.45 (CET)**. This event is a follow-up to this edition of MTb in which a number of the contributing authors will provide more detail on their articles, and discuss topical issues in global mental health.

SYMPOSIUM on **Friday 22nd of January from 14.00 to 17.00 (CET)**. 'MIND MATTERS', the annual NVTG symposium highlights current issues in the field of global mental health, with a special focus on mental health and psychosocial support (MHPSS).

Keynote speakers include:
Joop de Jong (psychiatrist, Em Prof of Cultural Psychiatry and Global Mental Health, Amsterdam UMC; Boston University School of Medicine),

Mark Jordans (Professor of Child and Adolescent Global Mental Health, University of Amsterdam; Director of Research and Development at War Child Holland; Reader at the Center for Global Mental Health, King's College London) and his colleague **Nagendra Luitel** (Head Research Transcultural Psychosocial Organization, Nepal; PhD Candidate University of Amsterdam).

Paul Bekkers, Special Envoy Mental Health and Psychosocial Support of the Ministry of Foreign Affairs.

Marit Sijbrandij, Associate Professor Clinical Psychology, Vrije Universiteit Amsterdam and the World Health Organization (WHO) Collaborating Center for Research and Dissemination of Psychological Interventions.

Rembrant Aarts, psychiatrist at Mentrum Mental Health, MD Global Health and Tropical Medicine (AIGT), will chair this session.

In the last hour of the symposium the Laureate of the first **Sauerwein Medal** will be awarded, we will launch the **NVTG Knowledge Centre Global Health**, and there is a session organized by **Uniting Streams** where young Global Health researchers will pitch their work.

Closing date for abstract submission: **9 AM January 15, 2021, at: unitingstreams.org**

Both events are online, free of charge, in English and accredited (NVTG, NVvP).

More information on: **nvtg.org**

Registration is required:
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For the symposium: **info@nvtg.org**

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