Working globally, thinking locally: Providing psychosocial intervention training in Sierra Leone

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Summary

This article reflects on the work of a project that brings Clinical Psychologists from Europe and the United States to Sierra Leone to train local workers in psychosocial interventions. Strengths, weaknesses, and opportunities associated with this work are highlighted.

Sierra Leone is a country in West Africa with a population of just under 6 million people. The motto of the country is 'Unity, Freedom and Justice'. However, between 1991 and 2002 the unity, freedom and justice of the country were shattered by a brutal civil war. It is estimated that 40-50,000 people were killed and 500,000 civilians fled the country (Dufka, 1999). In particular, women and children suffered high levels of trauma during the civil war. Approximately 50,000 to 64,000 internally displaced women in Sierra Leone have histories of war-related assault, while 50% of those who came into contact with the Revolutionary United Front reported sexual violence (Physicians for Human Rights, 2002). It is estimated that between 7,000 and 10,000 child soldiers may have been part of the fighting forces in Sierra Leone (Government of Sierra Leone, 2005). Gupta & Zimmer (2008) found high levels of intrusion, arousal and avoidance symptoms in 315 children aged 8-18 in assessments conducted 9–12 months after the war.

As an organization *commit and act* seeks to give people in areas of conflict access to psychotherapeutic support, regardless of religious, cultural or ethnic affiliation, especially in countries with little psychotherapeutic infrastructure (*http://commitandact.com/commit_and_act.com/home_engl..html*). In Sierra Leone the organization has been offering local people employed with Non-governmental Organizations

(NGOs) training in Acceptance and Commitment Therapy (Hayes et al., 2011). In February 2012, over 90 NGO staff attended the three workshops that were organized in Freetown and Bo. More recently, in February 2013, we (as representatives of *commit and act*) returned to Sierra Leone with other Clinical Psychologists to conduct further training. As with the previous year, over 90 people attended workshops that were organized in Freetown, Makeni and Bo. Further information about this trip is available online (www.rosswhiteblog.wordpress.com). The efforts that *commit and act* have made to train NGO staff in Sierra Leone are consistent with the WHO's call to scale-up mental health services in low and middle-income countries (LMIC) (WHO, 2008; 2010). In addition, *commit and act's* strategy of training lower skilled/paid staff to deliver these types of intervention (as opposed to psychologists or psychiatrists) is consistent with the notion of 'task-shifting' (Butteroff et al., 2012). It is important, however, to critically reflect on the strengths and weaknesses of the work that *commit and act* has been doing in Sierra Leone.

Working in LMIC can provide important opportunities for Clinical Psychologists trained in high-income countries to look afresh at the assumptions that underlie their practice. The mental health systems and services that are well established in the UK and other high income countries may be the envy of many countries across the world, but it could be argued that these systems also bring rigidity to how distress is understood. Summerfield (2008) claims that the predominance of 'Western' frames of reference for categorising and measuring mental health difficulties mean that the evidence-base for mental health interventions is not universally valid for the global population. White (2013) highlighted risks associated with globalising psychiatric systems of care and the detrimental impact that this might have on effective ways of coping. Working in LMIC settings where biomedical systems of care may be less well established, provides a tantalizing glimpse into alternative explanatory models for the distress that people experience.

Rather than focusing specifically on types of psychiatric diagnosis that may not be relevant or valid in Sierra Leone, *commit and act's* work in Sierra Leone focuses more broadly on particular types of difficulties that can be comparatively widespread in Sierra Leone. A recent report, for example, concluded that domestic violence is the biggest single threat to women's health in the West African countries of Sierra Leone, Liberia and Ivory Coast (IRC, 2012). Focusing on particular social problems (e.g. inequalities, gender-based violence, female genital mutilation, substance use, stigma associated with HIV/AIDS etc) in Sierra Leone provides an opportunity to utilise a *bottom-up* approach to developing measures and interventions for addressing these problems. It will be important for Clinical Psychologists working in LMIC to be sensitive to the social context: connecting with people's difficulties by understanding their interpersonal worlds; working to create an alternative context that will allow people to feel support and compassion; helping them come to a better understanding of themselves and others.

In our capacity as experienced ACT therapists and trainers, we felt confident in our ability to deliver the workshops. ACT conceptualises psychological suffering as being largely caused by our avoidance of certain emotions, and becoming fixated on particular thoughts. This leads to rigidity that impedes people's ability to be in contact with actual contingencies and to take functional behavioural steps (Hayes & Smith, 2005). As an antidote to this process, ACT aims to enhance psychological and behavioural flexibility and facilitates individuals to perform behaviours that are consistent with their values in life.. In essence, 'ACT seeks to deliver a unified model of behaviour change applicable to human beings in general, not just those fitting certain diagnostic criteria.... across a wide range of problem areas' (Hayes et al. 2012, p.978). Numerous scientific research supports this transdiagnostic approach, which tries to consider the clients historical, biological, psychosocial and cultural relations (Drossel, 2012) as important for the therapeutic process.

Research has indicated that mental health counseling interventions can be adapted and

implemented with positive outcomes across cultures (Bolton et al., 2007; Rahman et al., 2008; Verdeli et al., 2003; Tol et al., 2008; Jordans et al., 2010). However, ACT had never been previously trialed in an African context. Important questions needed to be addressed: will the approach be relevant to a culture that that may not share epistemological frameworks with those that are prominent in high-income countries; will the focus on intra-psychic phenomenon such as 'thoughts' and 'feelings' make any sense in more collectivist societies; and will the metaphors used to capture therapeutic processes be valid in low-income countries?

One particular aspect of ACT that offered promise regarding the cross-cultural application of the approach was the focus that it allocates to *values*. Values have been defined as: 'learned, relatively enduring, emotionally charged, epistemologically grounded and represented moral conceptualizations that assist us in making judgments and in preparing us to act…Values can be grounded in the cultural heritage of a society and pervasively housed within the institutions of the society.' (Frey, 1994, P.19). At the level of the individual, values have also been defined as freely chosen, verbally constructed, patterns of activity, which are intrinsically reinforcing (Wilson & Dufrene, 2008). It is suggested that values: 'help us to interpret and comprehend the behaviors of others as well as to guide our own behaviors through the mazeway of human existence' (Frey, 1994, P. 24). Although values may vary from culture to culture and from individual to individual, it is clear that the existence of values is common to all cultures and all individuals. The way in which ACT can empower individuals to tolerate distress and commit to value-consistent behaviors (which are in part culturally defined), may mean that ACT can translate across different cultures. For example, in Sierra Leone and the UK alike, ACT provides a framework for helping people to explore what is important in their lives (e.g. learning new skills and developing as a person) and be guided by this in how they move forward in spite of distress that may be present (e.g. worrying about not be able to cope). In apparent support of this cross-cultural utility, ACT has recently been used successfully in a non-Western middle-income country i.e. Iran (Mo'tamedi et al., 2012).

To help tailor ACT to the Leonean context, *commit and act* have invested heavily in training a select number of local people to become ACT trainers. One of these individuals, Hannah Bockarie, is now helping to co-facilitate workshops. We believe that empowering local people in this way will be hugely important for the longer-term sustainability of the development of psychosocial interventions in Sierra Leone. Hannah is able to combine her ACT training with her knowledge of the local culture to tailor the content of training to the Leonean population. This includes incorporating locally relevant metaphors and describing the ACT processes in local languages. Although the official language of Sierra Leone is English, the most widely spoken language is Krio. This is a corrupted dialect of English that has its origins in the English spoken by the freed slaves who travelled from the Caribbean to Sierra Leone in the 19th Century. There are also indigenous languages that reflect the tribal societies in Sierra Leone. The Temne and Mende languages are the most widely spoken. The tribal languages tend to be descriptive more than abstract. This can raise problems when discussing intra-psychic phenomena such as thoughts and feelings. This serves to emphasise the importance of tuning into local descriptions of distress and utilizing those phrases. We have learned much about how to engage with Leonean people through watching Hannah at work. So, although mental health professionals will have increasing opportunities to work globally, they must think and speak locally.

As an organisation, *commit and act* is committed to disseminating information about the work that it is doing in Sierra Leone. This form of knowledge exchange is vital for helping projects of this type to evolve. Representatives from *commit and act* evaluate the workshops that the organisation delivers. The findings of these evaluations have been presented at international conferences. The academic and clinical scrutiny that these presentations afford, provide invaluable opportunities to develop the work of the organisation. In conjunction with the University of Glasgow, *commit and act* is keen to establish programmes of research to support the work in Sierra Leone. During our recent visit to Sierra Leone, we were

accompanied by an MSc Global Mental Health student from the University of Glasgow. The student (Iain Mays) was conducting a qualitative research project into people's experience of the workshops offered by *commit and act*. Specifically, the interviews sought to explore how this training might influence the work that NGO staff do with their clients, and whether there were particular adaptations that people thought needed to be made to the approach. Important opportunities exist to extend this work and determine the extent to which borders of language, beliefs and practices impact on the relevance and validity of psychosocial interventions. We are in the process of submitting a paper to a peer-reviewed journal that reports on the acceptability and effectiveness of the training we have provided in Sierra Leone (Stewart et al., in submission).

Working in LMIC is not without its challenges. Sierra Leone is one of the poorest countries in the world. The resources and infrastructure available for meeting the mental health needs of the population are therefore very limited. The fabric of the buildings used to house mental health patients is old and decrepit, and there may be very little medication available to treat acutely distressed individuals. There is a corresponding lack of equipment available for training individuals involved in mental health-related work. Computers are a rare commodity, and projectors are practically non-existent. Even when this technology is available, the electricity supply may be unpredictable or absent. Consequently, the technology available to deliver workshops is lo-fi – flipchart paper, markers, masking type (for writing name badges), work-books and pens are as sophisticated as it gets.

In Sierra Leone, it has been estimated that the literacy rate is 45% for men and 18% for women (WHO, 2005). When facilitating workshops for staff working in LMIC it is important to be aware of the emphasis that can be placed on written materials to educate people about mental health difficulties. This also has important implications for measuring the severity of emotional distress in middle and low-income countries. Many of the mental health assessments are written self-report measures that have been developed and validated in high-

income countries. Efforts need to be made to develop measures that are relevant and valid for LMIC.

Finally, it is important to acknowledge that the broader context in which organisations such as *commit and act* work may serve to limit the likelihood of achieving meaningful change. Efforts need to reflect local priorities, local stakeholders must be afforded ownership over efforts to develop services and there needs to be a political willingness for this change. An up to date mental health policy will be required to support efforts, as well as legislation to protect the rights of those experiencing mental health difficulties. The specter of corruption can be a major issue in LMIC with individuals opting to prioritise their own greed over the needs of others. For too long 'Global Mental Health' has been what Kleinman (2009) has called 'a failure of humanity'. There is a moral imperative for change to occur, so that the lives of millions of vulnerable people can be improved. Putting pressure on the ministries to take on political responsibility and get government support for mental health will be hugely important for bringing about change in LMIC. Clinical Psychologists can play an important role in this process.

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