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Mental Health: A Forgotten Facet of Healthcare

This is my story

My calling to become a psychiatrist comes from an urgent need to address mental health in the Great Lakes Region

By Achille Bapolisi

The increasing number of people suffering from mental problems as a result of armed conflicts is alarming and in contrast with the paucity of resources allocated to mental health. In my case, that contrast has been perceived has a vocational call to specialize in psychiatry, a promising field that offers many therapeutic perspectives. My passion as a psychiatrist is the management of refugees coming from different countries. I meet patients who suffer from highly traumatic experiences such as war, rape or torture and who are from different cultural backgrounds. We use a holistic clinical approach which is adapted to our patient needs.

Psychotherapy session in a multicultural context conducted in Mbarara Regional Referral Hospital (Photo: Ali)

In the last decades several wars and armed conflicts have completely devastated most of the African Great Lakes regions (Burundi, the Democratic Republic of the Congo, Rwanda, and Uganda). No one is ready to forget the shocking 1994 Rwanda genocide which resulted in more than 800'000 deaths (Verpoorten, 2005). In the neighboring country Burundi, a civil war killed approximatively 300'000 people between 1993 and 2006 (Ngaruko and Nkurunziza, 2005). In the Democratic Republic of Congo (DRC) in 2008, 5.4 million people were estimated to have died as a result of the consecutive armed and persistent conflicts which have devastated the country since 1998, making it the more criminal war since the World War II (Moszynski, 2008).The toll has surely worsened during the last decade with the recent massacres.

It has been reported that in post-conflict areas, the rate of mental disorder is extremely high, war being the most stressful event that can occur in human life (Murthy and Lakshminarayana, 2006). Most specifically the wars that take place in those regions are characterized by flagrant human rights violations such as rape, torture, mutilations, civilian massive massacre… For example, in the Eastern part of DRC the prevalence of Post-traumatic Stress Disorder (PTSD) is estimated to be around 50.1% followed by major depressive disorder (41%), suicidal ideations (25.9%) and suicidal attempt (16%) (Johnson et al., 2010). Those exorbitant numbers in the prevalence of mental health disorders are in contrast with the shortage of mental health professionals and the lack of resources allocated to mental health in this region. In DRC there is only 0.9 mental health worker per 100'000 population (WHO, 2015).

Being Congolese myself I felt the need to contribute to the alleviation of mental health issues in the Eastern DRC. Based on my passion for psychiatry, I began a Master program in Psychiatry at Mbarara University of Science and Technology in Uganda in August 2015. There is no psychiatric program offered in the eastern Congo.

From my point of view, the amazing evolution of psychiatry with the increasing inputs from neurosciences, psychology and social sciences, has opened many promising therapeutic perspectives. Thus, it is unfortunate to have those affected populations deprived from adequate mental health care!

Focus on refugees living in South Western Uganda during my psychiatric training

In addition to many other academic and clinic missions, the psychiatric department of Mbarara University of Science and Technology provides mental health care to refugees coming from Nakivale Camp, in South Western Uganda. Nakivale Refugee Settlement hosts 80'000 refugees and asylum-seekers. There are nine nationalities of refugees in the camp including Congolese (42%), Sudanese (36%), Somalis (9%), Rwandans (8%), Burundians (3%), Ethiopian (1%),

Kenyans (0.5%) and Liberians (0.5%). (UNHCR, 2015). Because of my personal interest in trauma-related psychological disordersand my proficiency in some refugees' languages, I have been appointed to coordinate the refugees care in the Psychiatric ward of Mbarara Regional Referral Hospital.

> *Most of my patients went through highly traumatic events such as rape, torture, mutilation, witness of collective massacre or murder of a relative.*

The most prevalent disorders I get to see in the clinic are post-traumatic stressdisorder (PTSD), major depression, generalized anxiety and substance use disorders. Women, children and adolescents constitute to the majority of people attending the clinic. Most of my patients went through highly traumatic events such as rape, torture, mutilation, witness of collective massacre or murder of a relative. As a result of that they are presenting very severe and complex features of mental conditions such as somatization, dissociative features or psychotic symptoms. In addition they often face serious psychosocial stressors in the camp such as lack of food, unemployment, lack of education for children and safetyleading to the retention of symptoms.

Practice of narrative exposure therapy in Bukavu, Eastern DRC (Photo: VIVO)

Refugees show severe mental health disorders which require a holistic therapeutic approach

Beside coming from different countries, the refugees have different cultures which shape the clinical presentation and influence the therapeutic process. From this transcultural perspective, I realize the relevance of integrating each aspect of care, from the diagnosis to the treatment by including the cultural context. We therefore need to cautiously apply the standard psychiatric classification of diseases (DSM-V), use explanatory models and management approaches taking into account the cultural sensitivities. And finally the clinical management is challenged by the lack of resources. The high number of refugees presenting mental disturbances often overwhelms the local medical staff in the camp.

> *In short, this moving experience of taking care of highly traumatized patients is sometimes emotionally overwhelming and personally demanding; but it gives a unique opportunity to learn in a multicultural context on how to help refugees.*

It is worth mentioning that the Psychiatric Department of Mbarara University has partnered with the Office of the Prime Minister, with UNHCR, with Medical Team International (MTI) and with American Rescue Committee in supporting traumatized refugees. Our close collaboration with the psychiatric nurse, allocated by the MTI is very helpful in detecting new psychiatric cases in the community and in organizing follow ups of outpatients. The MTI also provides drugs and laboratory tests to our patients, ambulances and translation services in some languages.

In short, this moving experience of taking care of highly traumatized patients is sometimes emotionally overwhelming and personally demanding; but it gives a unique opportunity to learn in a multicultural context on how to help refugees.

Clinical practice: a constant search for efficient, adapted and affordable approaches

The psychiatric program of Mbarara University is made of theoretical presentations and practical training in diverse mental health related course units. In addition, I attended specific workshops in order to improve more specific therapeutic technics such as Narrative Exposure Therapy (NET), Dialectic Behavioral Therapy, motivational interviewing. The challenge of the clinical work, as far as refugees are concerned, is to develop an individual clinical approach for each patient with regards to his/her cultural background, specific personality traits, the level of trauma he or she experienced and the resources available.

Workshop on Narrative Exposure Therapy conducted in Bukavu (Photo VIVO)

I usually use pharmacotherapies to address severe cases of mental disorders. The selective Serotonin Receptors Inhibitors (SSRI) are the most used for depressive and anxiety symptoms. Sometimes for complex cases antipsychotic medicines are considered, preferably those of second generation. More cautiously, we use benzodiazepines for drug withdrawal or for the symptomatic treatment of anxiety symptoms. Those pharmacological approaches although very helpful to address some severesymptoms, need to be combined with psychotherapies to sustain the clinical improvement.

> *The majority of the patients would like to reduce intrusive symptoms resulting from PTSD, to improve the psychosocial functioning, and to reduce the social stigmatization. In particular women who were raped are quite often rejected by their families. Identifying the patient's specific needs is crucial in designing more realistic, appropriate and personalized approaches.*

In term of psychotherapy, I try to identify the explicit or implicit needs behind each consultation.The majority of the patients would like to reduce intrusive symptoms resulting from PTSD, to improve the psychosocial functioning, and to reduce the social stigmatization. In particular women who were raped are quite often rejected by their families. Identifying the

patient's specific needs is crucial in designing more realistic, appropriate and personalized approaches. I usually focus first on reducing the more disturbing or dangerous symptoms such as panic attacks, suicidal ideations, traumatic flash-back and nightmares and guilt.

Therefore, I use particular psychotherapeutic techniques. Psychoeducation is always necessary to explain to the patient what is happening with him- or herself. In addition psychoeducation has a very strong therapeutic effect. The resilience oriented supportive therapy aims to identify the intrinsic and extrinsic strengths and to improve the coping strategies of the patient. Usually relaxation techniques are used to reduce anxiety related symptoms. Cognitive therapies are used to identify and challenge common negative thoughts such as guilt, fatalism and worthlessness. It also helps patients to restore a positive perception of themselves and the world. For intrusive symptoms of PTSD I use the narrative exposure therapy which aims to face the traumatic event in view of integrating and overcoming the persistent sensorial, cognitive, affective and physiological disturbances caused by the trauma. The motivational interviewing and the dialectic behavioral therapy are usually used to enhance changes and to show new perspectives, especially in patients with substance usedisorders.

Quite often, specifically in the case of sexual assault, the entire family structure is disintegrated. That makes individual approaches insufficient. In those cases more systemic methods are necessary and couple and family therapies are indicated. With family therapies especially in case of sexual assault we aim to help the victim to express their feelings and to recognize the feeling of other family members. Most of the time it requires preliminary individual sessions to help each member of the family to identify and work on hisown guilt, self-blame and worthlessness which are often the base of the sadness and the anger he or she is expressing. Once the self-awareness is achieved, sessions of communication techniques help different members to express their feelings and also to understand the other members of the family. The last part of family therapy is to reconnect each member to common familial activities and projects such as the education of children or the general care of the family and to help each family member to recognize the significant contribution of each one has for the wellbeing of the entire family.

In summary, the clinical management with refugees is complex and requires a great deal of flexibility, creativity and improvisation in order to implement codified management approaches into particular contexts and amulticultural population.

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Kontakt

Deutschschweiz
Medicus Mundi Schweiz
Murbacherstrasse 34
CH-4056 Basel
Tel. +41 61 383 18 10
info@medicusmundi.ch

Suisse romande
Medicus Mundi Suisse
Rue de Varembé 1
CH-1202 Genève
Tél. +41 22 920 08 08
contact@medicusmundi.ch

Bank details
Basler Kantonalbank, Aeschen, 4002 Basel
Medicus Mundi Schweiz, 4056 Basel
IBAN: CH40 0077 0016 0516 9903 5
BIC: BKBBCHBBXXX