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Providing Psychotherapy for the Poor

Innovative counseling programs in developing countries are repairing the psyches of civil war survivors and depressed mothers alike

By Mason Inman

It had been four years since 13-year-old Mohamed Abdul escaped civil war in Somalia, but he still had nightmares and flashbacks. When he was nine years old, a crowd fleeing a street shooting trampled him, putting him in the hospital for two weeks. A month later he saw the aftermath of an apparent massacre: about 20 corpses floating in the ocean. Soon after, militia-men shot him in the leg, knocked him unconscious, then raped his best friend, a girl named Halimo.

Recovering in the hospital, Abdul (not his real name) was overwhelmed by fear—and guilt, for not having helped Halimo. He felt unprovoked fury: he mistook people he knew well for the rapist and threatened to kill them. A few months later Abdul fled his homeland and landed in the Nakivale refugee settlement in Uganda. “I felt as if there were two personalities living inside me,” he said at the time. “One was smart and kind and normal; the other one was crazy and violent.”

Abdul had post-traumatic stress disorder (PTSD), an ailment characterized by fear, hyperarousal and vivid replays of the traumatic event. Fortunately, this refugee camp had an extraordinary resource. Psychologist Frank Neuner of Bielefeld University in Germany was offering “narrative exposure therapy” to its 14,400 Africans, mostly Rwandans. The approach coaxes trauma survivors to assimilate their troubling memories into their life stories and thereby regain some emotional balance.

After four 60- to 90-minute therapy sessions, Abdul’s flashbacks and nightmares disappeared; he was still easily startled but no longer felt out of control. His doctors deemed him “cured.”

Researchers and aid workers have historically overlooked mental health in developing countries, focusing instead on issues such as malnutrition, disease and high infant mortality, but that is changing. “What’s changed in the past 10 years is the realization that mental health is not separate from general health,” explains child psychiatrist Atif Rahman of the University of Liverpool in England.

Recent psychotherapy trials have achieved remarkable success in improving the lives of war survivors such as Abdul, poor mothers with postpartum depression and others victimized by the stresses of extreme poverty. The keys to a workable program for the impoverished include training ordinary citizens to be counselors and, in some cases, disguising the remedy as something other than a fix for emotional troubles.

Treating Trauma

Although many people think of mental illness as a plague of fast-paced modern life, some psychiatric ailments are actually more prevalent in the developing world, according to the World Health Organization. Of the several dozen wars and armed conflicts around the globe, nearly all are in developing countries, and this violence is leading to PTSD, which hinders recovery after the conflicts subside. Across South Asia, new mothers suffer from depression more frequently than they do in richer countries, according to a 2003 report by Rahman and his colleagues.

People in underprivileged nations also experience more severe economic stresses. “This pileup of adversities is associated with low mental health,” says sociologist Ronald Kessler of Harvard Medical School. For individuals living on the edge of survival, the economic ramifications of a mental illness can be especially devastating. When someone has a major mental illness, “you’ve lost their labor and their input,” notes mental health researcher Paul Bolton of Johns Hopkins University.

To make up for the deficit of mental health care professionals in the developing world, Neuner and his team recruited refugees from the camp. Anybody who could read, write and be empathetic was a candidate. Because nearly one third of the Rwandan refugees and half of the Somalis suffered from PTSD, many of the would-be counselors needed to be treated first.

For a PTSD sufferer, distressing experiences are divorced from time or place and out of sync with the person's life story. "Once these memories are activated, usually the interpretation of the brain of what's happening is that there's a danger right now, because the brain is not really aware that it's just a memory," Neuner points out. "We want to nail down this vivid emotional representation. We want to bring it where it belongs and connect it with your life history."

Accordingly, refugee therapists spent six weeks learning to help patients shape their lives into a coherent story, incorporating major traumas into the narrative. The strategy worked. Seventy percent of those who received the therapy no longer displayed significant PTSD symptoms at a nine-month follow-up assessment compared to a 37 percent recovery rate among a group of untreated refugees.

Empowering Mothers

In Rawalpindi, a largely rural district of Pakistan, nearly 30 percent of new mothers become depressed—about twice the rate in the developed world. In addition to its toll on mothers, postpartum depression can harm babies' emotional and, in South Asia, physical development. Most of these women consider their symptoms the fate of poor folk or believe that they are caused by *tawiz*, or black magic. Many are anxious about talking about their problems and being labeled as ill. What is more, Rawalpindi has only three psychiatrists for its more than 3.5 million residents.

To get around such stigmas and barriers, Rahman and his colleagues recruited government employees known as lady health workers to integrate mental health therapy into their home visits to mothers. Ordinarily, these workers visit homes 16 times a year to give advice on infant nutrition and child rearing.

A two-day course enabled these health workers to add mental health to their curriculum. Rahman's approach is based on cognitive-behavior therapy, in which a counselor tries to correct distorted and negative ways of thinking either by discussing them openly or by suggesting more adaptive behaviors. If a mother said she could not afford to feed her baby healthful food, for example, the lady health worker would question that assumption and suggest incremental improvements to the baby's diet. A year after giving birth, mothers given this psychologically sensitive advice showed half the rate of major depression of those who received traditional health visits. The strategy worked by empowering the women to solve problems, Rahman believes.

More efforts to bring psychiatry to the poor are under way, such as a trial in Pakistan in which community health workers help to ensure that schizophrenics take their medications. But the biggest hurdle is scaling up these treatments to meet the great need.

Note: This article was originally printed with the title, "Psychotherapy for the Poor".

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