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Treating mental health in conflict zones in Burkina Faso with Traumatic Stress Relief (TSR)

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In the particularly degraded context of Burkina Faso, two non-governmental organisations have joined forces to provide mental health care. A look back at an experience of transposing a method used by health workers who are not mental health specialists.

Since 2018, the security crisis in Burkina Faso has exacerbated the humanitarian crisis, contributing to major population displacement[1] and a health system in disarray, with the closure or reduced hours of health facilities. As of September 2022, 197 health facilities have been closed, *i.e.* 13.6% of the total number.[2]

Growing needs but shrinking healthcare provision

Reduced access to healthcare and population displacement are increasing pressure on primary care facilities in the areas receiving the displaced, mainly due to the growing numbers of people attending health centres. At the same time, exposure to attacks and massacres, the harrowing experience of being displaced and the permanent anguish caused by a state of insecurity are contributing to a rise in mental health problems.

This increase in mental health needs is taking place against a backdrop of a low level of provision, despite the existence of a *Plan stratégique santé mentale* (Strategic Mental Health Plan).[3] Most of the qualified and specialised mental health professionals are based in urban areas, whereas the healthcare workers at health centres have received little training or information on how to identify, refer and treat mental health issues. At community level, the subject of mental health is poorly addressed and even considered taboo.

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[1] OCHA, Burkina Faso : aperçu de la situation humanitaire (au 31 décembre 2022), https://reliefweb.int/report/burkina-faso/burkina-faso-apercu-de-la-situation-humanitaire-au-31-decembre-2022
[2] Corus International, *Bulletin n° 32 du Cluster Santé du Burkina Faso*, septembre 2022, https://reliefweb.int/report/burkina-faso/bulletin-ndeg32-du-cluster-sante-septembre-2022
[3] Ministère de la Santé du Burkina Faso, *Plan stratégique santé mentale 2020-2024*, décembre 2019, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/plan_strategique_sante_mentale_2020-2024_2.pdf

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Incorporating mental health into the humanitarian response

ALIMA and its local partners, Keoogo and SOS Médecins – Burkina Faso, are dealing with the challenge of supporting mental health services in order to meet these growing needs. This task is further complicated by insecurity and the disorganised health system, particularly in the Centre-Nord region of the country. ALIMA's assistance has been incorporated into the existing health provision to guarantee continuity of care through the Ministry of Health. Community workers are trained in awareness raising – specifically to put an end to mental health taboos – and in the early detection of mental health issues, which helps limit the risk of complications. Workers specialising in Mental health and psychosocial support (MHPSS) deliver first line care in health centres and through mobile clinics. Mental health is linked to medical and nutrition work, *i.e.* each contact with health workers is an opportunity to raise awareness and to detect and treat mental health issues. If necessary, patients are referred to psychiatric services. In terms of nutritional care, apart from detecting issues in mothers, health workers are trained to spot any cognitive or developmental issues. Psychostimulation areas, which allow for play sessions with children and the accompanying persons, have been set up.

Innovating to provide trauma care

Trauma Aid France is a non-governmental organisation (NGO) founded in 2004. The organisation aims to deliver training and develop psychotraumatology and Eye Movement Desensitisation and Reprocessing (EMDR) in France and abroad. EMDR is a comprehensive neuro emotional psycho-therapy, based on the principles of the Adaptative Information Processing (AIP) model. It is a pathogenesis, mental health and change model, whose main premise is that symptoms are caused by partially processed and dysfunctionally stored information. The untreated emotional and somatic trauma can be triggered at any time, which leads to a sufferer avoiding situations or people, causing problems in their day-to-day life, even long after the event. One participant, a woman who had been forced to flee her village, was finding it hard to look after her child, as she was so overwhelmed by flashbacks: "The threats made by the armed men unsettled me so much that I felt unsafe wherever I went."The AIP model describes the mechanism enabling the process of treating and coming to terms with traumatic experiences, thus reducing traumatic stress. Indeed, neuroscience has shown that this information processing system is sensitive to alternating, bilateral brain stimulation, such as alternate left/right tapping on the shoulders, knees, or moving the eyes from left to right. For this process to work, it is important that sufficient psychological resources are available (a previous success, feeling supported by the community, a positive sensory experience, etc.).

Recommended by the World Health Organization (WHO) for treating post-traumatic stress disorder (PTSD), EMDR has many benefits: no work is required between sessions and its swift delivery after an event reduces the symptoms of traumatic stress and prevents the

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symptoms becoming worse.[4] The development of EMDR has led to the implementation of group therapy protocols in the aftermath of major disasters. These protocols have proved to be particularly effective in reducing traumatic stress, while offering high levels of protectionto those involved.[5]

The latest advances in the upscaling of traumatic stress care have led to the development of tools that are transferable to professionals who are not mental health specialists. Within this arena, the Global Initiative for Stress and Trauma Treatment (GIST-T),[6] an initiative designed to extend access to trauma care worldwide by decentralising care, has developed a Traumatic Stress Relief (TSR) training course, using techniques borrowed from the AIP model.

This course has been rolled out as part of the partnership between ALIMA and Trauma Aid France, with the aim of developing and trialling innovative solutions to meet the mental health needs of conflict-affected populations, notably when displacement occurs in places where the health systems were already crumbling.

Training health workers who are not mental health specialists

The innovative approach involves training non-mental health specialists so that they are able to deliver first and second line trauma care using the TSR method. In 2021, seventeen people were trained (three nurses, two psychologists, one doctor, four midwives and seven mental health workers) to apply TSR to internally displaced people (IDP) and members of the host community in Burkina Faso.

TSR

Training takes four to five days followed by supervision over several months. The TSR programme includes the acquisition of skills and know-how on understanding and identifying psychological trauma, psycho-emotional stabilisation, and running a group protocol to reduce trauma based on AIP, called the Worksheet Protocol (F-WSP).[7] The training is focused on practice and group discussion, using experiences in the field, to ensure training is as useful and effective as possible. It is designed to be tailored to different cultures and contexts.

The F-WSP is an adaptation of another protocol, G-TEP,8 normally used by specialists trained in EMDR, aimed at non-mental health specialists. Each participant is given an A3 sheet of paper with coloured sections to help them follow the process guided by a

[4] Elan Shapiro and Louise Maxfield, "The efficacy of EMDR early interventions", *Journal of EMDR Practice and Research*, vol. 13, no. 4, 2019.
[5] Safa Kemal Kaptan, Busra Ozen Dursun, Mark Knowles *et al.*, "Group eye movement desensitization and reprocessing interventions in adults and children: A systematic review of randomized and nonrandomized trials", *Clinical psychology & psychotherapy*, vol. 28, no. 4, 2021.
[6] GIST- T, Global Initiative for Stress and Trauma Treatment, https://gist-t.org
[7] Elan Shapiro & GIST-T, "WorkSheet Protocol for the Frontline", *TSR Guide for frontline, non therapist personnel*, August 2019, pp. 31–62.
[8] Elan Shapiro and Judy Moench, *EMDR Group Traumatic Episode Protocol (G-TEP) Manual (7th edition),* 2018, https://emdrresearchfoundation.org/toolkit/gtep.pdf

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facilitator. Facilitators attend the group to ensure that the process runs smoothly and help group members follow the steps. The F-WSP is unique in that it makes use of a large number of resources (a good memory for the person, a quiet place or activity, hope for the future, etc.), which are added to the sheet as participants advance through the process. Positive resources are shared among the group, while negative and painful content is simply put down on paper and remains confidential. Difficult events are desensitised using alternating, bilateral brain stimulation in conjunction with multiple resources. This helps reduce a person's trauma while leaving them in a tolerable emotional state.

The results of a feasibility and accept-ability study carried out in the African Great Lakes region9 and feedback from health workers trained in Burkina Faso show that the teaching method is suitable for teaching many culturally acceptable or relatively easy-to-adapt tools. However, additional cultural adaptation efforts were required. This was made possible through role play to anticipate any barriers. Once on the ground, the trained workers were able to adapt the way the concepts and emotional stabilisation exercises were explained through, for example, the use of imagery or breathing techniques, metaphors more in tune with the culture and objects symbolising emotions. Interestingly, although not being personally traumatised was one of the prerequisites for taking part, roughly one-third of the staff receiving the training had clinical PTSD scores. Since the training also enabled self-care and peer care, their PTSD scores went down following the training.

The training setting also enabled techniques suited to the local environment to be identified or ruled out. Consequently, some stabilisation techniques proved to be unsuitable in their original form, as they focused on unpleasant physical sensations before switching to a more pleasant feeling, with the effect, opposite to that intended, of reawakening traumatic memories that were disturbing for participants. This was taken on board in order to adapt the content of the techniques to be rolled out on the ground by non-specialists. Most of the stabilisation techniques are quick to implement and therefore easy to apply.[10] The F-WSP Traumatic Stress Relief protocols do, however, require more organisation and only workers accustomed to dealing with people, in groups or one-on-one, found it easy to implement them.

Implementation

During health centre appointments, patients identified as presenting symptoms of traumatic stress were advised on the different treatment options available to relieve their symptoms, individually or in groups, in line with this impact assessment. One of the challenges of supporting displaced people is their lack of stability. It is therefore important to ensure that they are able to access psychological first aid, are emotionally stable and can receive TSR intervention within a short timeframe.

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[9] Adeline Pupat *et al.*, "Global initiative for stress and trauma treatment - traumatic stress relief training for allied and para-professionals to treat traumatic stress in underserved populations: A case study", *European Journal of Trauma & Dissociation,* vol. 6, no. 2, 2022.
[10] Adeline Pupat *et al.*, "Global initiative for stress…", *art. cit.*

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The TSR intervention process was as follows: after explaining the method, volunteer participants attended a psychoeducation session and answered a questionnaire to measure their level of traumatic stress (ITQ) and resilience (BRS); they were then included in a TSR group protocol if their state was considered suitable for this type of treatment. The method was adapted to the context, including providing the tools translated into the Moore language and support to people unable to read or write. Seventy-six out of ninety-two people were able to attend the group sessions, and sixteen were referred for an individual consultation. Most of the participants were able to attend all three planned sessions, held on the same day with plenty of breaks.

Results

The beneficiaries were 95% IDP with the remaining 5% from the host community. The host community is also under pressure because they are living in danger, albeit in their usual environment. As for the IDP, some were able to return to their families, who then provide support and understanding. However, in both cases, the unstable context affects daily functioning, which can lead to disputes. Family issues and interpersonal conflicts consequently account for 13% of events causing traumatic stress that people chose to address during F-WSP; armed attacks 21%, theft and property loss 7%, displacement and associated food insecurity 18%, and the loss or death of close family and friends or sick children 23%. Of the participants, 91% were women, largely because they attend health facilities in greater numbers than men, and 78% are unable to read and write.

The questionnaires were completed again one week and then one month after the group therapy session in order to measure its effectiveness. The quantitative and qualitative results show that the participants derived real benefit from the intervention, with a significant drop in traumatic stress symptoms, regardless of the number of sessions (one or three), with 96.7% of people reporting an improvement.

Regarding resilience, a significant increase in resilience was recorded among people who had three sessions of F-WSP. However, there was no improvement in this area for those who only attended one session. The intervention beneficiaries showed improvement in their daily lives. The above-mentioned participant reported that: “TSR did me a lot of good, and I am now better at managing my anxiety. […] I have been able to overcome this trauma thanks to TSR.” Furthermore, from among the tools provided by the TSR intervention, the beneficiaries liked being able to visualise their stress level with a visual scale known as Subjective Units of Distress Scale (SUDS) in order to regularly apply the learned stabilisation techniques.

What prospects for traumatic stress treatment in conflict zones?

By keeping an open and creative mind to culturally adapt an approach validated by neuroscience for treating traumatic stress and its psychosocial consequences, and therefore supporting resilience, TSR is a promising approach. It helps improve access to emergency mental healthcare in conflict zones and could in all like-lihood be replicated in other contexts, with different populations. The limitations of this study are the difficulty

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involved in culturally adapting the tools, the fact that only health workers with prior experience could apply the F-WSP protocol and the limited timescale for measuring the impact of the intervention (under two months). The cultural validity of the questionnaires also needs to be tested. New awareness strategies need to be developed to enable more men to be reached. The aim is to develop a clinical trial that will enable the TSR method to be validated over time and scaled up.

Translated from the French by Gillian Eaton

Biographies

Dodo Ilunga Diemu • Dodo Ilunga Diemu is from Lubumbashi in the Democratic Republic of the Congo (DRC) and is currently the Mental Health and Psychosocial Support Coordinator for ALIMA in Burkina Faso. After studying at the University of Kisangani Faculty of Psychology and Education (DRC), he worked as a psychologist and coordinator at a psychosocial support centre in Maniema (DRC). He then held several posts with Doctors Without Borders – Belgium and then Doctors Without Borders – Spain as a supervisor then a psychologist and mental healthcare manager. He has held the post of Mental Health and Psychosocial Coordinator with ALIMA in Burkina Faso since September 2020. His role includes developing the NGO's mental health and psychosocial support strategy and the care and referral pathway in its areas of intervention.

Adeline Pupat • Adeline Pupat is a clinical psychologist and EMDR-Europe therapist in private practice, specialising in the diagnosis and care of psychological trauma and dissociative disorders, and an official TSR (GIST-T) trainer. Adeline has sat on the Trauma Aid France executive committee since 2016 and is a member of the *EMDR pour Tous* committee run by NGO EMDR France. Her clinical practice and research firstly focused on chronic pain, coping, psychiatric trauma and dissociation in response to traumatic events. Currently, her field of practice and research centres on treating the psychotraumatic consequences of violence and exile, individually and in group settings, and studying the development of strategies borrowed from Adaptative Information Processing (AIP) that are transferable to non-mental health specialists.

Victoire Hubert • After graduating in International Development (Sciences Po Paris) and Public Health for Development (London School of Hygiene and Tropical Medicine), Victoire Hubert joined ALIMA in 2014, firstly focusing on fundraising and managing donor contracts. She held various roles in ALIMA's countries of intervention before specialising in public health, with a particular interest in medical research projects. From 2018 to 2020, she coordinated a clinical trial of an innovative strategy for treating acute malnutrition in the Kasaï region of DRC. She has held the post of research manager at ALIMA since 2020. Victoire is tasked with monitoring the various research projects and supporting the field teams in order to develop new research topics.

Harouna Yacoubou • Following a Master's in Psychopathology and Clinical practice in 2016, Harouna Yacoubou started his humanitarian career as a clinical psychologist and mental health services supervisor for Doctors Without Borders – Spain in Diffa (Niger). He was tasked with providing psychosocial support to IDP and refugees from Nigeria and supporting and supervising mental health counsellor-educators and community mental health workers. Since March 2021, Harouna has been the mobile mental health specialist for the NGO ALIMA in Burkina Faso, supporting several projects, specifically those in the Nord and Centre-Nord regions. These are the areas most affected by population displacement caused by the armed conflicts. His remit notably involves service rollouts, clinical case monitoring, training, support and coaching of mental health and psychosocial support staff and partner relations.

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Jean-Pierre Alley • Jean-Pierre Alley is an ALIMA mental health specialist based in Dakar. Jean-Pierre is a Doctor of Clinical and Health Psychology and a psychotherapist, with 16 years of experience, specialising in humanitarian psychology, general psychopathology, child and adolescent psychopathology, couples' and family psychology and psychoactive substance addiction. Before ALIMA, he worked for the French Red Cross and *Terre des hommes* in Lausanne. At the same time, he worked as a research professor and lecturer in the Clinical Psychology, Health Psychology and Neuropsychology Department of the University of Lomé and the Psychology Department of the University of Sonfonia in Conakry. Jean-Pierre has also worked in private practice as a consultant and general manager of the *Cabinet d'Expertises psychologiques et psychosociales appliquées au développement* (psychological and psychosocial consultancy services applied to development) in Lomé, Togo, primarily covering the African continent.

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