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Standardisation challenged by local dynamics: the example of mental health programmes in the Chad Basin

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This article is based on a study carried out by Groupe URD in Niger, Nigeria, Cameroon and Chad. The authors' approach, based on the social determinants of psychological disorders, allows us to better understand the logic that individuals follow in order to identify the therapeutic trajectories that enable them to relieve their suffering. And they are often at odds with international and biomedical standards.

The destruction of any form of social cohesion, peace and individual resistance is the weapon used in most present-day conflicts, including those in the Chad Basin. The physical and psychological abuse inflicted by members of Boko Haram and non-State armed groups is the morbid instrument of a political drama whose aim is to "stun" a whole society. Terror is used as a means of controlling populations: it is the core component of modern political violence, orchestrated to penetrate the social universe of whole communities and individual psyches. It is in this context that thousands of families flee their villages and their production space to migrate towards reputedly safer areas. However, even if this relative safety allows them to stay alive, it obviously does not provide the conditions for a decent existence. Fragmented family and village units, uncertain access to resources and an economy recreated based on "getting by", anxiety arising from displacement and resettlement in a little-known environment devoid of social structure: there is no lack of nested causes of trauma.

Mental health and the crisis in the Sahel

In this context of ongoing crisis, care pathways are broadly structured in three stages: recognising suffering, searching for its cause and then treating it. Three types of care are involved in the therapeutic trajectories: home care, "traditional" remedies and medical treatment. However, far from being linear, these types of care and the stages in them may be considered complementary, the quest for healing justifying all healthcare approaches. In this respect, the different ways of accessing healthcare and managing mental illness coexist, without competing against each other, the supply of biomedical treatment on offer being so scarce. Though primary care is almost exclusively dispensed in a traditional or faith-based setting, access to psychiatric and psychosocial services is determined "by default", according to the availability of services provided by the State or international organisations, or when other attempts at traditional treatment have failed. In fact, the

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idea that people turn to traditional healers due to a lack of "more appropriate" treatment is largely false. Rather it is the opposite that emerges from the various testimonies: psychiatric services, on account of the stigmatisation linked to using them, are generally feared since they visibilise and institutionalise "madness". In addition, being entirely centred on the individual, psychiatry ignores the social dimension of suffering.

Traditional medicine, on the other hand, is a socially acceptable remedy since it links a disorder to causes that are not personal but arise from outside the individual and "is part of normal care practice and a shared aetiology,[1] unlike psychiatry".[2]

It therefore seems inappropriate to talk of the resilience of the populations in this region any more than of stabilised and permanent social circumstances. It is rather a case of multiple individual strategies, medical pluralism[3] and therapeutic syncretism[4] at work, each trying to mobilise the social, economic or symbolic capital at their disposal to address suffering and deal with the uncertainty of an imminent end to the crisis.

Confrontation between international standards and local healthcare strategies

The analysis that is the subject of this article[5] addresses the methods of adapting mental healthcare programmes and international standards to local dynamics in populations affected by the crisis. It shows that understanding "mental health" in a crisis context is not only a question of a concept (trauma) or a diagnosis (such as that of post-traumatic stress disorder or PTSD) but also of analysing local dynamics linked to the care of subjective suffering and the place society reserves for the sufferer. This reflection seems all the more necessary since the systematic and unconditional use of international standards and impact measures appears to be reaching a new scale in the aid and mental healthcare sector.

Published for the first time in 1952, the Diagnostic and Statistical Manual of Mental Disorders (DSM)[6] has developed an increasingly category-based approach to mental illness. As with any standardised assessment tool presupposing a universalist conception of a phenomenon (here, trauma), the diagnosis of PTSD does not leave room for a detailed

[1] Aetiology is the study of the causes of disease.
[2] Véronique Petit, « Circulations et quêtes thérapeutiques en santé mentale au Sénégal », *Revue francophone sur la santé et les territoires*, 2019.
[3] Definition of "pluralism" by the *Centre National de Ressources Textuelles et Lexicales* (CNRTL, www.cnrtl.fr): "A doctrine or practice that accepts the coexistence of different cultural, economic, political, religious and social elements within an organised community" [our translation, Editor's note].
[4] Definition of "syncretism" by the *Centre National de Ressources Textuelles et Lexicales* (CNRTL, www.cnrtl.fr): "Fusion of different cults or religious doctrines [...], mixing, fusion of elements from different cultures or social systems" [our translation, Editor's note].
[5] This article is based on qualitative research carried out by Groupe URD between March 2021 and May 2022 in Niger, Nigeria, Cameroon and Chad. This study was funded by the European Union and the French Development Agency (*Agence française de développement* – AFD) under the RESILAC project. The multidisciplinary team included the experts Ibrahim Yamien (Niger – psychiatrist), Ignace Bertrand Ndzana (Nigeria – anthropologist), Henri Mbarkoutou Mahamat (Chad and Cameroon – political scientist), Galy Mohamadou (Chad and Cameroon – psychologist), and Florence Chatot (researcher and study coordinator, Groupe URD).
[6] Some informations about the Diagnostic and Statistical Manual of Mental Disorders: https://www.psychiatry.org/psychiatrists/practice/dsm

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interpretation of the different forms of illness and the influence of contextual determinants in the development of pathologies.[7]

In the context of the Sahel where the aetiology and nosography[8] used in traditional medicine differ from those of biomedicine, this system of classification may appear unworkable. Even when the disorder in question can be identified and related to a category of PTSD diagnosis, it is indeed highly likely that the associated therapy is not available, at least not on a long-term basis, and that the medication prescribed (again according to the DSM) is unobtainable in the country in question. In other words, it may be ineffective to confine pathological signs to pre-set categories when these categories convey nothing in the reference country. Trying to match the two forms of nosography seems also a risky venture as it always comes down to classifying sufferers in categories of illness or treatment. However, there are no such things as "Western diseases" or "African diseases" but just different ways of naming, understanding and treating them.[9]

Deconstructing – rather than measuring – the concept of well-being

In the aid sector, the calculation of the prevalence of psychiatric disorders is subject to increasingly complex statistical processing as technical instruments "advance" and become more widespread and standardised. However, this more general and standardised use of tools runs the risk of producing results that are themselves more generalising and standardised and so neglecting markers of diversity and particularity specific to the practices and representations surrounding mental illness, notably in the countries of the Sahel.

Indeed, knowing how many people have a symptom does not help us understand why they are so affected, nor establish their individual coping mechanisms and the collective inclusion or exclusion dynamics concerning these persons: inherently unquantifiable questions which consequently elude any attempt at classification and categorisation. Thus, when the statistics show the gap between the realities of sub-Saharan Africa and the objectives of the global agenda, it is certainly worth analysing these realities in depth, but it is also important to question the standards themselves.

When underlining the mismatch between the supply of healthcare and people's mental health needs, priority is effectively given to the accessibility of medicines and healthcare services. This also implies that access to care rationales and the sufferers' room for manoeuvre are minimal if not non-existent. What is more, when the emphasis is on this

[7] Christian Lachal, Lisa Ouss-Ryngaert and Marie Rose Moro, *Comprendre et soigner le trauma en situation humanitaire*, Dunod, 2003.
[8] Nosography is the discipline that deals with the systematic classification of diseases.
[9] In this respect, the universalist ambition of classifications must not lead to excessive particularism or culturalism, the harmful effect of which would be to strictly confine the individual in their own "culture" and to consider "the individual only exists as a member of their community of origin" (Alain Policar, « La dérive de l'ethnopsychiatrie », *Libération*, 20 juin 1997). As expressed by Didier Fassin referring to the ethnopsychiatry of Tobie Nathan, this comes down to advocating "radical differentialism which gives a person's origins, most often referred to in ethnical terms, an intractable and immutable dimension": Didier Fassin, « L'ethnopsychiatrie et ses réseaux. L'influence qui grandit », *Genèses. Sciences sociales et histoire*, n° 35, 1999, p. 146-171.

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"discrepancy", the analysis is distorted through a perception in terms of "lack" and "deficiencies", and thus by extension focuses on "what should change". Admittedly, the aid sector is driven by this demand for change and improvement (of institutions, actors, services, procedures, etc.) – this is even its key purpose – but by emphasising too much "what should be" there is a risk of overlooking and deviating from the analysis of "what really is or exists".

In fact, because it is often easier to find a "local" (even if distant) equivalent to a model than to question this model, the use of statistical tools and psychometric scales designed to measure and/or diagnose psychological suffering is problematic. Indeed, the increasing requirement of funders and of the World Health Organization (WHO) to produce measurable outcomes very often demands that projects use these scales as tools to analyse and evaluate well-being. In this regard, the example of the WHO well-being index (WHO-5) is very revealing since it is based not only on an extremely subjective notion and evaluating any improvement in it, but it also includes a considerable number of cognitive and methodological biases. Apart from the fact that the questionnaire calls on entirely artificial recollections ("over the last two weeks"), that it uses resolutely positivist terminology which is difficult to translate ("I felt lively and full of energy", "I woke up feeling refreshed and ready for anything"), and that it is based on a very unrealistic incidence of "well-being" (more than half the time, less than half the time), evaluating the final score is meant to "reveal" the level of well-being in a rational way.

It goes without saying that this type of survey, if it is delivered "as it stands" to the populations concerned, may be more likely to elicit incomprehension than to detect illness. It is nevertheless widely used by aid organisations as "evidence" to justify the achievement of intervention outcomes. In this regard, mental healthcare programmes often boast of an "increased level of well-being" among their recipients on the basis of this very index. However, in reality, whether the "objective" of improving well-being is reached or not, nothing is said about the social and psychological determinants which influence both well-being and malaise, and nothing either on addressing these determinants, an analysis that is nevertheless central to the preoccupations of those working in the mental healthcare sector. As a result, the use of well-being indices in populations who have experienced suffering to such an extent that even the idea of "well-being" seems entirely relative, should be considered with caution.

Finally let us remember that using subjective measurements to produce evaluations of well-being was initiated not by psychologists but by economists. Since the end of the 1990s, the growing interest in measuring subjective well-being has even contributed to the birth of a new branch of economic science: "the economy of happiness",[10] characterised by measuring quality of life and social development. Therefore, a more nuanced view of the explicative value of well-being indicators should be taken, in the same way as it would be interesting to question the increasing influence of "positive psychology" in the context of emergency and enduring crisis.

[10] Jinan Zeidan, « Les différentes mesures du bien-être subjectif », *Revue française d'économie*, vol. XXVII, n° 3, 2012, p. 35-70.

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Indeed, national and international mental health policies which are increasingly based on a positive approach to psychology[11] focus above all on quality of life and well-being, on what makes human beings resilient, happy and optimistic, rather than on the origins of disorders. This tendency has been characterised for some time already by a certain semantic shift which consists of speaking of mental health rather than mental illness, of social cohesion rather than social conflict, of resilience rather than breakdown. But this linguistic evolution is not entirely innocuous. The imposition of "norms of well-being", condemned by some researchers as having a highly political purpose,[12] is also reflected in the increasingly demanding expectations regarding the "capacity" of populations to be resilient and to achieve "happiness". On the one hand, the drive for well-being leads insidiously to making individuals who may not have reached the objective of the desired "individual development" or who have not been able to "solve their problems" feel guilty in spite of their recourse to sophisticated protocols.[13] On the other, it tends to disempower outside interventions that often associate any failures with "failures of capacity" of populations and constantly "reinforce" these capacities the nature of which they themselves defined (economic development, resilience of territories, social cohesion, etc.).

However, in our opinion, mental health and resilience are not concepts the presence or absence of which should be sought in a given population, for which expected results are stated and impact indicators measured. They are less an "operational objective" than all the social and individual behaviour occurring when a society or individual is in a situation of distress and has to face this using their own strategies and resources.

Integrating endogenous care methods

The challenge of mental healthcare programmes seems therefore to avoid pathologising suffering using classifications with a universalistic vocation and to understand, without any preconceptions or judgements, the meaning systems associated with mental suffering as well as the endogenous procedures for treating this suffering. Indeed, whether the

[11] This positive approach in psychology presents itself as complementary to the traditional approach and aims to study the conditions and processes contributing to the optimal functioning of individuals, groups and institutions: Shelly L. Gable & Jonathan Haidt, "What (and why) is positive psychology?", *Review of General Psychology*, vol. 9, no. 2, 2005, pp. 103–110; C. Martin-Krumm & C. Tarquinio, *Traité de psychologie positive*, De Boeck, 2011, https://oraprdnt.uqtr.uquebec.ca/pls/public/docs/FWG/GSC/Publication/1935/46/3976/1/53089/10/F1222518819_33_3_263.pdf; Martin Seligman & Mihali Csikszentmihalyi, "Positive psychology: an introduction", *American Psychologyst*, vol. 55, no. 1, 2000, pp. 5–14; Michael Dambrun, « La psychologie positive: une approche nécessaire et complémentaire ? », *Les cahiers internationaux de psychologie sociale*, vol. 1, n° 93, 2012, p. 15-20.

[12] Cécile Collinet et Matthieu Delalandre, « L'injonction au bien-être dans les programmes de prévention du vieillissement », *L'Année Sociologique*, vol. 64, n° 2, 2014, p. 445-467; Claude-Olivier Doron, « L'émergence du concept de "santé mentale" dans les années 1940-1960 : genèse d'une psycho-politique », *Pratiques en santé mentale*, vol. 61, n° 1, 2015, p. 3-16. According to this latter, one of the key functions of mental health is to convert potential social conflict, whether in industry or in developing countries, to individual "intrapsychic" conflicts or interrelational conflicts between individuals, that must be resolved "in a harmonious manner".

[13] World Health Organization, *Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity*, 2018, https://prevention-collaborative.org/wp-content/uploads/2021/08/WHO_2018_Project_Management_Plus_PM.pdf

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illness is given a biological or mystical interpretation, the most important things are the individual and collective resources mobilised to deal with disorders. In this respect, the power of the symbolic effect on the patient's recovery – whether the essence of this effect is divine or mystical – has long proved its effectiveness in a wide range of social contexts.

It is also worth underlining the fact that, since Hippocrates, biomedical science has considered illness only as the reflection of an individual disorder.[14] Consequently, when doctors diagnose a disease in an individual, they name it and attribute it to a cause, but never to the will of an invisible being situated outside the patient. It is nevertheless this type of investigation that is involved in traditional therapies, whether marked by customary, religious or esoteric beliefs, or all three: social and cultural dimensions supersede the biological.[15] Traditional medicine has effectively retained its sacred and spiritual nature since disease is seen as the result of an attack from outside. Healers focus on the underlying cause of this aggression and the diagnosis or treatment stems from the identification of this cause. Thus, a paranoid psychosis – as it is termed in biomedicine – may equally be read by traditional medicine as possession by a maleficent being, an evil spell or the result of transgressing social or religious norms. What remains constant, whatever the name of the pathology, its meaning or its cause, is the belief that each individual must invest in the healing effort. This is because ultimately, the issue here is not to seek a universal truth but rather to understand what each society considers as real and effective in the face of subjective suffering.

In Niger for example, a practice reported by a traditional healer is to ask the patient to speak into an empty bottle and to spit into it when something painful has been said. The healer then seals the bottle to symbolise the removal of the traumatic event from the subject's mind and proceeds to bury the bottle. We may not believe in the bottle's ability to trap the painful experience, but this makes no difference to the effectiveness of this practice based on the act of liberating speech. This example helps us understand the parts played by the symbolic and the therapeutic in traditional medicine.

Putting thoughts into words by reactivating elements from the past is a core practice of psychoanalysis. This practice also exists in traditional medicine since most healing rituals, whether magical or religious, start by listening to what the patient and/or the family has to say. The possibilities of collaboration between the two types of approach lie probably in the identification of these common features. This collaboration would ensure populations would take mental health programmes on board to a greater extent and would have the advantage of addressing the concerns of relatives and friends, without challenging the meaning and interpretation they attribute to suffering.

This approach, firmly focused on the social determinants of mental illness and the perception of therapeutic efficacy, guided our work. Our main objective was to gain insight

[14] Andras Zempleni, « Livre 5. Les rites de possession chez les Wolof et les Lebou du Sénégal », *Anthropologies et sociétés*, vidéo, 2018, https://www.anthropologie-societes.ant.ulaval.ca/videos/andras-zempleni-livre-5-les-rites-de-possession-chez-les-wolof-et-les-lebou-du-senegal
[15] René Collignon, « Les conditions de développement d'une psychiatrie sociale au Sénégal », *Présence Africaine*, vol. 1, n° 129, 1984, p. 3-19.

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into the rationales that come into play when an individual experiences mental health problems and to determine the therapeutic pathways and scope for action available to populations to overcome suffering in a fragile context.

We believe that understanding these rationales and incorporating them in international strategies are among the prerequisites for successful intervention in mental healthcare. This would in fact enable projects to adapt to local support dynamics and become a more integral part of the care pathways for those affected and their families. It would have the additional benefit of addressing the concerns of loved ones, without undermining their interpretation of their suffering and the meaning they attribute to it.

Translated from the French by Fay Guerry

Biographies

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