Beyond 'voluntourism'

Thomas Campbell on mental health and volunteering in Sri Lanka

As a graduate aiming for a career in clinical psychology, my search for relevant experience has taken me far and wide. From working as an Autism Support Worker, to entering data for a counselling charity, to completing a person-centred listening course, I've been getting familiar with the mental health field in the UK for a couple of years. My latest venture plunged me into a foreign culture in the developing world and exposed me to a diverse range of professionals and clients as I joined SLV on their Graduate Mental Health Volunteer Placement in Sri Lanka.

Prior to this placement I was largely aware of Sri Lanka in relation to two major tragedies in recent history: the bloody civil war between the Sri Lankan government and Tamil separatists, ending in 2009 after 26 years; and the 2004 Indian Ocean tsunami which killed around 35,000 and displaced more than 800,000 Sri Lankans. Whilst I, of course, knew that there would be far more to this island nation of 20 million inhabitants than the sorrow and misery of these two events, I did expect that my volunteering experience would be largely coloured by their repercussions. What I encountered was a diverse range of people and situations that were not limited to the trauma of war and disaster. I expected the challenges posed to mental health in this developing nation to differ from those in the UK but found that the most prominent issues were, in fact, similar. Yes, the scale of the challenge here was certainly magnified, but in general the issues of stigma, lack of understanding and an extreme lack of funding, resources and care-availability were the main barriers to improving mental health.

Stigma and awareness

Stigma around mental illness is a global challenge and has been described as the main obstacle to provision of care for people with mental illness. Sri Lanka is no different, and countless professionals I spoke to identified stigma as a major problem in society. Religious and cultural beliefs permeate public attitudes, and the concept of karma – that there is a causal relationship between someone's present circumstances and their actions in a previous life – seems to justify blaming victims for their mental illness. Yet contrary to my expectations, more rural communities in which traditional beliefs were strongest actually appeared to display more acceptance of their mentally ill than industrialised communities.

In an urban suburb I saw a culture of abandonment on a weekly basis at the psychiatric institute and rehabilitation centres we worked in. Owing to some archaic legislation the female patients here can only be discharged by the family member who signed them in. Often these family members are not easily traced and so societal reintegration following admittance is generally low, prompting one psychiatrist I spoke with to quip: 'Half Way Home is a misnomer; it's Forever Home.' Indeed, whilst we were working there, the institute was officially full. Despite this, over one third of the patients leave the facility to work each day, returning in the evening, and with no intensive security there is not a feeling of detainment, only one of hopelessness.

Contrast this with the support and acceptance I witnessed on a field trip to a psychiatric outreach clinic in the rural north. Here it seemed that the traditional family unit was stronger than in urban centres where life has taken on a more Westernised, individualistic flavour. Whereas those in cities seemed excluded from the fast-paced lifestyle, the rural mentally ill enjoyed greater social integration. Many had been medicated for years, but maintained their roles as farmers, shepherds and mechanics. It seemed the simple, manual nature of their work had some remedial quality that allowed them to maintain their routines in spite of their conditions. This seems to chime with Waxler's findings some 40 years ago (tinyurl.com/hapjxaa), of better reintegration for the mentally ill in non-industrialised Sri Lanka. This urban–rural dichotomy suggests, perhaps, something inherent in Western industrial culture that is geared towards exclusion of the mentally ill.

Another common issue was a lack of

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awareness and understanding around the concept of mental health, and of what support is available. Again, related to traditional beliefs, people would often attribute a person's poor mental health to a vengeful god or possession by a spirit. In one outreach clinic a war victim who had lost his sight in an explosion presented with panic attacks and vivid, intrusive memories. This was his first contact with any mental health service, a full seven years after the war had finished. It seemed that, after trying traditional healing to no avail, he was visiting the clinic as a last resort.

The psychiatrist, a minority in his staunch atheism, let us know in no uncertain terms his feelings about the traditional religious healers who often charge high rates for their rituals: 'They prey on vulnerable, simple people and their practice stands in the way of science.' Yet he recognised the need to meet people on their level, and to be sensitive to their personal convictions whilst encouraging them to use the service he provided.

Availability

Mental health care is highly underfunded in Sri Lanka with approximately one psychiatrist per 500,000 inhabitants and, according to one counselling service, zero psychologists outside of Colombo. Needless to say, the medical model is dominant and yet still falling short of demand.

We witnessed the noble efforts of the psychiatrist in the north and his outreach clinics: bringing care to the people. But in general, without motivated and exceptional professionals like him, the isolation of many communities means the impracticality of travelling into a town with a hospital makes it highly unlikely that they will: with poor roads and irregular buses, travelling even 50km to reach a hospital can take all day.

One organisation we worked with was Samutthana (www.samutthana.org.lk), a psychological service set up by King's College London whose focus is on 'supporting the development of more holistic and less medicalised services that promote recovery, and that people can access in the community'. Their team of trained psychologists and counsellors provide therapies such as CBT, eye movement desensitisation and reprocessing, and narrative therapy. Their efforts span the entire country, but they are a small organisation and represent a rare example of good mental health care. One counsellor from Samutthana admitted that any type of psychotherapy outside Colombo is extremely unusual and that, within the city, it is only really available to privately paying clients. It seems that most people's options are limited to pharma-psychotherapy. That's a shame because, according to Samutthana, therapies such as CBT lend themselves quite easily to Sri Lankan culture. The Buddhist view that 'we are what we think' works well with CBT's emphasis on adjusting thought patterns. There are issues with converting Western-developed therapies such as CBT from English to Sinhala, with some of the psychological language and concepts not translating smoothly, but, it appears, with a creative, flexible practitioner, psychotherapies such as CBT could represent a viable alternative to medication.

Making a difference?

One of my biggest concerns was whether the work I did would make any difference or merely serve as token 'experience' for my CV. I expected that a major limiting factor here would be the language barrier. Whilst SLV's staff comprises 90 per cent Sri Lankan nationals, they are generally there to coordinate logistics and not to interpret attempted interventions. Perhaps my attempts to support patients in introspection and emotional expression were over-ambitious. I would privately despair when my 'emotions wheel', complete with painstakingly transcribed English to Sinhala instructions, became yet another colouring template, or when our planned drama session to encourage 'perspective taking' at a boys detention centre descended into a free-for-all. At times I questioned the point of it all. Doing arts and crafts, or leading a stretching routine, seemed somewhat shallow and redundant when patients were suffering from chronic depression or schizophrenia.

However, I came to realise that the 'point of it all' is that we are dealing with fellow human beings, and that we can make connections and share experiences that transcend spoken-language barriers. Of course we are not going to cure schizophrenia by throwing a ball around, but by going in with warmth, empathy and acceptance – core conditions that are essential to any therapeutic alliance – we can create the right environment to have fundamental human experiences such as sharing a laugh, a smile or simply a quiet moment sitting together.

I don't know the reality of living in an institution in Sri Lanka, but I can see that it is not a fulfilling existence. Volunteers coming in with enthusiasm and energy may go some way to brightening the otherwise colourless week for these patients. From the feedback we received via nurses and psychiatrists, the patients loved the sessions run by the 'white people' and looked forward to those few hours where people tried to connect with them as humans.

I also had initial concerns about 'voluntourism'. There is a whole industry composed of organisations offering short-term breaks combining exotic travel and a minor volunteering role. In theory these represent a win–win situation: contributing to local communities; personal development and experience for volunteers. However, there have been many flaws highlighted in this type of enterprise, such as unethical 'for-profit operators'; skills-gap between volunteers and community needs; and importing neo-colonial attitudes.

SLV seem to address these issues well. Volunteers are selected on the basis of their background skills and experience (only one in six applicants are selected, according to their statistics) and their respect for local culture was stringent. Furthermore, at between one and three months, SLV's placements are longer than most voluntourism organisations' one- to two-week placements, which reinforces the continuity and consistency of the support they offer to communities. Different batches of volunteers come and go, but the projects run year-round, and with each new batch comes a replenished source of ideas and enthusiasm.

Final reflections

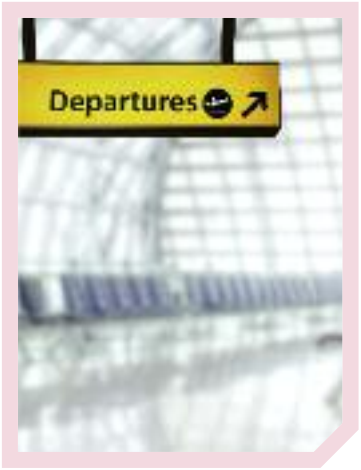
I gained both an interesting insight into mental health in a foreign culture, and the opportunity to develop my personal skills and qualities. Being challenged to provide support for vulnerable people with language barriers has broadened my understanding of basic human connection. SLV provided a reasonable platform for volunteers to make a difference here, both for themselves and for the communities they work with. Beyond this it is up to the individual to put in the effort to learn from, and reflect on, the situation they are in.

Despite being separated by over 5000 miles, cultural differences and a socio-economic chasm, the challenges facing mental health are similar between Sri Lanka and the UK. Stigma, awareness and availability. Motivated, dedicated people who have the skills and personal qualities necessary to make a range of mental health interventions widely available. I hope that through this experience I have taken some valuable steps on my journey towards being one of those people.

A cautionary tale

Megan Prowse presents her personal reflections on overseas placements

Working towards a goal such as a career in psychology – as any graduate or on-the-ball undergrad knows – can be difficult and at times frustrating. Getting good work experience on your CV is one of the most suggested ways to start working towards that goal, but this can be a job in itself. As an undergrad, I wrote to many NHS departments offering shadowing and assistance within departments, but for the most part to no avail. I found it hard to get good-quality work experience and with the ever-growing competition for admission onto doctorate training I was naturally attracted to a UK-based organisation offering oversees psychology placements. With the promise of exposure to hospitals and working closely with patients, they understandably said it was an opportunity hard to come by in the UK. I understood all too well how challenging working towards being on a training course can be, but I now offer this cautionary tale.



Volunteering abroad may fill a gap in the CV, but it is paramount that placements are responsibly and ethically organised. I also wish to suggest to the psychology community ways that we as practitioners can assist those wanting to be in the field, so there is less temptation for graduates to resort to potentially unsafe placements.

The unique selling point of the placement overseas was the chance to be in direct contact with patients on wards. Psychological work experience, not easily available in the UK, all for less than £2000 for up to three months. It sounded great so I signed up along with many others. As I arrived and we became orientated to the placement and what would be involved, confusion set in quickly followed by a heart sinking feeling that I had been ill-informed and ultimately missold the experience. With the addition of being thousands of miles away from home, I felt utterly disappointed.

In reality, the organisation offered psychology placements that entailed a variety of volunteering projects working on rotation. Although having signed up for a psychology placement you can, in fact, find yourself doing many different voluntary projects completely unrelated to psychology. The amount of time spent in a psychologically related institution was once, maybe twice in the week with the rest of the time spent teaching children to swim (without the request of qualification from the organisation and no lifeguard), or watching children playing. When finally in an institution and on a ward, there was no information given about the service, no notes or information given about patients, and neither the staff nor patients were able to communicate in English. Volunteers often asked the organisation if they could implement more meaningful activities, but the feedback was consistent that volunteers shouldn't question the organisation. The tagline quickly became clear: we 'wouldn't get this experience anywhere else' and therefore needed to be grateful.

It quickly became apparent that there were safety issues on the placement. For example, alarm bells were raised as my questions around risk management for volunteers on forensic wards were met with the vague response that we 'didn't need to think about that' as we were not in the UK. The safety concerns continued, as I observed the project's organisational staff knowingly encouraging volunteers to enter unpredictable wards where nurses were absent. Incidents did occur, where volunteers were being grabbed, pulled and scratched. Volunteers felt that they were unable to report this to the project's organisational staff, due to their 'lucky to be here' defensive attitude to the feedback from volunteers.

> "there can be a vast discrepancy between what is sold and what is provided in reality"

This apparent disregard for the safety of patients and volunteers alike left me questioning the awareness of the organisation's staff, with regard to psychological institutions and the necessary ethical considerations for working with vulnerable adults. I was also saddened by the lack of consideration for ethical and psychological factors for patients. For example, the organisation were not concerned with the potential disruption caused to patients by a regular presence of new people who were not staying long, who didn't speak their language and were not permitted to provide them with any real support. We were encouraged to walk onto the ward without any introduction or warning. Yes, there is value in basic contact for certain patients who may be left for long periods of time without visitors, but I wondered if sending us in to sit on the ward, simply looking at patients, was helpful for them and the best use of volunteers' time and money.

The organisation may have started out with good intentions, but the obvious lack of awareness for a safe and ethical placement is deeply concerning. I felt the organisation had a huge responsibility to provide something meaningful for patients and volunteers but to me there was an exploitative feel to the placement. I made the decision to end the placement early and do my best to speak up so that others wouldn't be in the same position. I do feel the organisation provided an experience: of another country, living with families and being immersed in a different culture. So why not sell it this way? Instead, the organisation promised a chance to work psychologically with patients for a fee, which turned out to be a promise left very much unfulfilled. At every turn the staff batted away constructive feedback and I couldn't help but feel that the organisation exploited the censorship in the country to defend against their failings.

So what could and should be done?

Firstly, in terms of safety, offering some risk-awareness training, to enable staff to be more on board and aware when volunteers are around. Improvements in the placements could include activities that are more useful to patients and

psychologically related for volunteers, properly liaising with the hospitals so that placements are integrated into the hospital services and that staff are aware of the volunteers' presence. Observations of doctors and professionals working with patients could also be provided if the placement was more integrated into services. Ultimately, providing a psychological placement should include some psychological elements, and if this is not feasible then the experience should be sold as it really is: at best, a cultural one.

Volunteering in mental health should be rewarding for those doing the work but more importantly should be meaningful for patients. Why should volunteers sign up and pay for these projects that are unsafe and do not provide any real psychological work? I believe mental health providers here in the UK need to consider how to include volunteers in departments. Often confidentiality is the reason for not offering volunteers a placement. However, there are ways to respect confidentiality whilst offering psychological work. For example, I was lucky enough to be offered observations of clinical psychologists providing psychoeducational groups (where disclosure of information and confidentiality constraints are limited), in exchange for providing administrative duties. Such an arrangement meant that I was contributing to the service and gaining meaningful experience. Departments can often overlook the contribution graduates with knowledge of IT and research skills can make. Offering up graduates, or eager undergrads, to help in departments is a key resource to be thought about, and in return a chance for eager psychologists in the making to be learning their profession.

I therefore urge professionals in the field to truly consider the value of volunteers. If we could offer more opportunities in the UK then perhaps these organisations will not have the chance to hold out the promise of things that they cannot deliver on. In sum, I write this cautionary tale, not to deter any good intentions of those trying to offer volunteers placements abroad, but as a warning to graduates to be aware of what is out there. Ethical and safety considerations aside, there can be a vast discrepancy between what is sold and what is provided in reality. Check what you're paying for, and whether you should be paying at all.

I *Megan Prowse is a CBT therapist: see www.citypsychchick.com*

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