TRANSCRIPT

EPISODE 4: Trauma & Storytelling

Hosted by: Rebecca Richards

Guest: Dr. Ayesha Ahmad

Transcripts may have been edited for clarity.

Rebecca: Hello and welcome back to Just Emergencies.

I'm Rebecca Richards and I'm here today with Dr. Ayesha Ahmad who's a lecturer in Global Health at St. George's University of London. And we're today to talk about the connection between epistemic justice and mental health during humanitarian crises.

[Intro Music]

This is "Just Emergencies"**,** the podcast where we show that global health emergencies are anything but just. In each episode we explore an issue, question, or event that makes us think about global health emergencies, humanitarian crises, and how to best respond to them.

Without further ado, let's get into the episode!

Rebecca*: So hi and thanks so much for joining.*

Dr. Ahmad: No, thank you.

Rebecca: *Could you tell us a little bit about yourself and your work, please?*

Dr. Ahmad: Yes, of course.

So I'm a lecturer in Global Health. But actually my background is quite unexpected, how I ended up in global health. So initially I was a philosopher, specialised in medical ethics. I also studied psychoanalysis at the side and specialised in trauma. And I always had a strong interest in trauma and conflict. Particularly understanding how women survive conflict, given the stories I was exposed to when I was younger. But I didn't really know that was a field until I progressed in my career. And that's how I was led to global health.

When I started working in global health about four years ago, I then had the opportunity to specialise and develop some research proposals to work on developing trauma therapeutic interventions in chronic conflict or humanitarian settings. So primarily the work is in Afghanistan, but we currently are working in Kashmir and also in Turkey and another project's also in South Africa.

Rebecca: *Obviously a big theme of our overarching project, which you're a collaborator on, is this idea of epistemic injustice. So could you tell us a little bit about the connection between epistemic justice and mental health and psychological suffering that happens during and after humanitarian crises and war and why it's an important issue, please?*

Dr. Ahmad: Yeah, so the trauma intervention that we've been working on is based on traditional storytelling. And the aim of having a trauma therapeutic intervention that draws on existing literary poetry resources in the countries we work on, which have very rich storytelling traditions. There's an important symbolism there between the voices that we hear and the voices that are spoken.

So, in conflict, there can be systematic silencing of women's stories of suffering. But also from the more structural, therapeutic, biomedical frameworks that have been designed primarily in Western populations, in non-conflict settings; the frameworks and understanding of how to conceptualise a woman's narrative, of the agency of a woman, or normative judgements of a voice. We often hear phrases such as 'giving voice to the voiceless', so there's an

assumption that those women do not even have a voice. But actually, there's a huge difference between - a crucial difference between - being silent and being silenced.

So part of the response to this interaction between epistemic injustice and mental health was to understand concepts of suffering in different contexts, but also for the women to be the agents of their own stories and the stories that they describe, rather than from formulating questions relating to different aspects of what we perceive to be suffering. So rather than asking for narratives of violence to be relayed and then communicated globally, we want to understand more about the meaning of that suffering to women and the stories *they* consider to be the most important relating to their lives.

Rebecca: *And once you have those stories, is the idea that the storytelling itself is a therapeutic mechanism, and/or is it that once we hear these stories that can hopefully better inform the therapeutic interventions that will be put in place?*

Dr. Ahmad: Well ideally, both.

The stories are supposed to frame suffering as a form of story. So if we look at some of the phrases for example, in Pashto and Darī about how if somebody's perceived to by another person to be suffering, they might be gifted some words which translate to 'your sorrow is going to make you a storyteller'. So it's about understanding the integration of suffering into your life, but how to frame that as a story and the meaning that that story can have for the person, even if it's traumatic. So it's a way of having a non-medicalised understanding of suffering in those contexts. So there's a therapeutic aspect there about the story.

But also then drawing on existing resources. In countries like Afghanistan, for example, there's an extremely rich cultural heritage for centuries of the role of poetry and stories that are passed down from generation to generation. Conflict interrupts this flow. But stories become an important point of reference in the society and part of the intervention is referring to…for example, in focus groups using poems from famous female poets who've experienced violence and have

translated that into a poem as a prompt or a way to be able to reflect on and relate it to your own stories. Developing a connection there so your story is not so much in isolation.

Rebecca: *And you said there that you have workshops and groups. But you also mentioned the intergenerational storytelling that is very important. So when you use the word 'storytelling', what does that involve? The communicative aspect there, what does that involve?*

Dr. Ahmad: Yeah, so we've had several projects now based on storytelling. And the aim is to ... the intervention is going to be contextualised depending on where you're working.

So the work we initially did in Afghanistan, that was involving semi-structured life-narrative interviews. We asked questions such as 'Can you tell us a story, a song or poem that you can remember from your childhood?'. And the woman would talk about those stories and where they heard those stories, why they were remembering them, what stories they remembered or referred to in the times they were suffering. We asked them about stories of other people who have suffered: why do they perceive that to be a story of suffering? So we used that structure to understand the meaning of a story more.

But also then, for example in the work with SHAER - which is Storytelling for Health, Acknowledgement, Expression and Recovery - which is now our current project, working with Kashmir, there we've worked with colleagues to develop a particular intervention that's specific to that context. And some of the different forms of applying storytelling involves women to try to describe the continuation of their story as a way to find agency in a context where the structural violence and the conflict has been very restrictive to stories they can live themselves.

Rebecca: *So you mentioned there the systematic restriction on women's voices and stories. So, to me, that sounds like the way that we treat epistemic injustice. The way we look at it, there's these two components. The first being that we don't assign enough credit to the speaker. The other being that there's this language*

missing around the speaker's experience so that there's a mismatch between the speaker and the listener. So, your project to me, sounds like you're tackling - or hoping to tackle - both of those aspects, where you're both giving voice to the silenced, which I guess is that phrase you're not too fond of. Or magnifying the voice of silenced and also trying to get a better language and understanding of their experiences. Is that right?

Dr. Ahmad: I wouldn't say that we're 'giving voice' or 'magnifying the voice'. The voice is already there, the voice is already magnified. The structures around that voice are what creates the silencing. So part of these interventions is to deconstruct those structures of silencing. So there's two aspects.

One from the psychological, therapeutic aspect. So if we look at the contemporary psychological therapies that are used, they rely on disclosures of suffering. You have to disclose violence that you've experienced in order to referred to the relevant resources and health support. The psychological assessments require your disclosures, your testimony, in order to analyse and see the threads of what then becomes classified as your symptomology to lead to a diagnosis. So we want to move away from that medicalisation, that almost forced disclosure, of a particular view of what a narrative is: that it's something that's happened in your past, impacts on your presents, and creates a foreboding future. So we're trying to move away from that.

At the same time, there's also creating spaces within societies. So if you have a society where your regime has banned women from reciting poetry, even having a space within a very secure location, where women can speak their poetry, that is a symbolisation. Because this work is... when we're thinking about epistemic injustice in the context of conflict and conflict related violence, gender based violence, and psychological trauma resulting from that, then we also have to think 'well, the suffering is not borne from the women themselves'. If you reduce the woman to a victim and if you reduce her suffering to symptoms, then it becomes a very pathological view of trauma. We are trying to understand the trauma that is mediated within a society. So in order to treat the trauma of a woman, we also have to treat the society. So it involves individualised

therapeutic intervention, but also interventions that have a societal, symbolic space as well.

Rebecca: *You've touched on a couple of things there that should be changed, or should be looked at differently. What's the overarching way forward or potential way forward that you think could help in addressing some of these issues?*

Dr. Ahmad: I think fundamentally, it comes down to an ethical reflection on the concepts that we use when we are prescribing other people's stories or other people's suffering. What are the inherent values that are part of the frameworks that we use to design psychological therapies? Who is contributing to that design? What are the ethical implications and assumptions when that biomedical framework is employed and implemented in these contexts that we are working in?

So I think it fundamentally comes from: we need to be very critical from an ethical perspective, first of all about the concepts and where those concepts come from. Because that's where this gap, the stem of the epistemic injustice, is.

Rebecca: *Ok, so obviously this has been so much about storytelling and voices and learning. So if people do want to learn more, what kind of resources could you recommend? What are the voices that people should be listening to and learning more about?*

Dr. Ahmad: For that I'd recommend actually referring to literature of particular countries. Being very mindful of who the authors are. You will see very high-profile biographies or even autobiographies, depicting violence that has been experienced. But thinking about 'Well, who has written this? Who has narrated this person's story?'.

You will see stories that are of... actually there's one at the moment about a woman in Pakistan called Ayesha and she's in the UK, but she's relating... she's exploring her family's story of violence. But it's narrated... the book is written

by a British man. It's not written by Ayesha herself. So thinking about, actually trying to access, even if it's folklore, or traditional stories, or poetry. At least those are authentic voices. And then you can see what is being mirrored in those words from that context.

And I think that's more where we find that truth and the antidote to epistemic injustice. And thinking critically about the sources where we read for information.

Rebecca: *Well thank you so much for sharing your knowledge, and your voice, in this episode. It was very interesting. Thank you very much.*

Dr. Ahmad: Thank you.