AFRICAN JOURNAL OF TRAUMATIC STRESS

Volume 2 Number 1, June 2011

A publication of
Makerere University College of Health Sciences
In Collaboration with Peter C. Alderman Foundation

Cover story:

1. *A counsellor at a centre for traumatized children in Gulu Province, Uganda, uses art therapy as part of the treatment for a former child soldier. http://www.acdi-cida.gc.ca/inet/images.nsf/vluimages/childprotection/$file/child-soldiers.pdf*
2. *Child soldiers are a common site in African conflicts.*
3. *Small arms are widespread among pastoralist communities in East Africa (file photo)*

South Sudanese children displaced by attacks by the rebel Lord's Resistance Army (LRA) in the town of Mundri, Western Equatoria state, where some 8,000 Sudanese have gathered fleeing the guerrilla raids

AFRICAN JOURNAL OF TRAUMATIC STRESS

Published by Makerere University College of Health Sciences

ISSN: 2218-4937

Correspondence

Please address all inquiries and article submissions to:

The Editorial Secretariat

African Journal of Traumatic Stress, Department of Psychiatry, School of Medicine,

College of Health Sciences, Makerere University

Mulago Hospital Hill, P. O. Box 7072, Kampala, Uganda.

Tel: +256 312 513469

Email: ajts@gmail.com

Website: www.ajts.or.ug

ABOUT THE AFRICAN JOURNAL OF TRAUMATIC STRESS

The African Journal of Traumatic Stress (AJTS) was established after the long realization of the need for all workers caring for traumatized people in Africa, to communicate to each other, to share experiences, knowledge, skills and to support each other. It was realized that there was a need to document and communicate all this knowledge to a wider audience beyond the African continent for the world to know, appreciate and help the traumatized peoples of Africa in the context of the now globalized increase of torture and organized violence as well as other man-made and natural disasters.

The primary objective of the AJTS is to provide a forum for discussion and presentation of papers to enhance the care and rehabilitation of the traumatized people's of Africa and beyond and ultimately to contribute to prevention efforts to eradicate this evil of torture and organized violence from Africa and the world at large.

The AJTS will publish original papers from wide and far-reaching multi-disciplinary backgrounds, including research papers, field experiences, new innovations in care, reports, commentaries, book reviews and even personal stories. Evidence-based papers will be of paramount importance. Short communications, newsworthy reports, review papers, cross cutting issues as well as picture-stories will all be welcome. The AJTS does not espouse any particular ideology/philosophical view but believes in the universal respect to human rights for all, in good participatory democratic governance and in the empowerment and protection of vulnerable groups and all peoples from exploitation and oppression and advocates for an end to warfare and all its industry; and for peace, freedom and justice for all the peoples of the world irrespective of race, colour, creed, ethnicity, religion, gender, age or political persuasion.

All opinions and articles published in the AJTS will reflect views of the authors and not necessarily views of the Journal. Prejudicial and hate literature will not be allowed. The authors will have to accept the terms and conditions as outlined in the "Guide to Authors" page of the Journal. Papers submitted to the AJTS will not have been submitted for publication elsewhere. After acceptance for publication, the author(s) will transfer copyrights of the accepted articles to the AJTS unless if accepted by the copyright holders.

The AJTS is published by Makerere University College of Health Sciences in collaboration with the Peter C. Alderman Foundation (PCAF). There will be two issues per year. For more information please contact the AJTS website www.petercaldermanfoundation.org

TABLE OF CONTENTS

ABOUT THE PETER C. ALDERMAN FOUNDATION

The Peter C. Alderman Foundation is a non-profit organization established by Dr. Steven and Mrs. Elizabeth Alderman to help traumatized survivors the world over to heal from the mental health effects of trauma.

The Foundation is named after Peter C. Alderman, the second son of the Aldermans who was killed in the September 11, 2001 terrorist attacks on the World Trade Centre, New York City, USA. He was at the tender age of 25. In memory of their son, the Aldermans, together with friends and relatives, decided to do something positive about their grief, hence the Foundation.

The Foundation's mission statement is "To heal the emotional wounds of victims of terrorism and mass violence by training doctors and establishing trauma treatment centres in post-conflict countries around the globe."

As part of its mission, the Foundation works to alleviate the suffering of war survivors in communities affected by conflict. The Foundation aims to provide holistic mental health care including (but not limited to) physicians, psychiatric clinical officers, psychiatric nurses, counselors and psychiatric social workers in these areas and to equip them with the tools to treat mental disorder using western medical therapies in combination with local healing traditions.

To fulfill this mission; the Foundation provides services in the areas of:

1. Mental health care to war affected persons through supporting "Trauma Treatment Clinics."
2. Psychosocial support to vulnerable peoples like formerly abducted children, former child soldiers, victims of rape, war widows, single mothers and HIV/AIDS patients in the war affected communities.
3. Training health workers in the war affected areas in the management of the mental health effects of war.
4. Awareness raising, sensitization, mobilization and holding training workshops on management of trauma.
5. Research in the mental health effects of war trauma on the population.

To achieve these objectives the Foundation works with and within existing Ministry of Health structures of the host country. In Africa, the Foundation currently supports work in Uganda (three trauma clinics and soon to open a fourth clinic) and Rwanda (one clinic) and is soon to open up a service in Liberia and Kenya.

PETER C. ALDERMAN FOUNDATION

Sowing the seeds that heal the sorrow

EDITORIAL

Healing the wounds of trauma is at the heart of the Peter C. Alderman Foundation (PCAF) as it is at the heart of all NGOs dealing with conflict and post-conflict situations.

Central to this exercise are the trauma workers themselves who may be from the areas of conflict themselves or from elsewhere, including coming from outside the country. The trauma workers go under a variety of names and have varied backgrounds ranging from lay therapists, faith healers, traditional healers to highly trained ones like nurses, social workers, psychologists or psychiatrists.

Whereas the principle of giving therapy may be standardized, their various experiences may not. Often the therapists may have different motivations for engaging in this work. Therapists from areas of conflict may themselves have suffered trauma and may be suffering from their own post-traumatic disorders. On the other hand, in giving therapy, all therapists, irrespective of background, do experience the pain of listening to and seeing the trauma on the victims. Often the therapists may feel traumatized (vicarious traumatisation), may feel fatigued/burnt out by the exercise or may develop counter-transference reactions to the patients or the perpetrators. Moreover, they work in very hard conditions of poverty, misery and adversity. Others have been direct targets of the conflicted parties who may see them as taking sides as they advocate for the rights of their clients or the down-trodden.

Caring for care givers (therapists) therefore becomes the central theme of any trauma work. The literature is full of what could be done for therapists and these include:

i) Short periods of exposure to the work with frequent holidays to allow for refreshening
ii) Adequate training and preparations for the therapists including cultural re-orientation
iii) Good pay, good supervision and good peer support
iv) De-briefing at the end of each exposure
v) Assessment of possible psychological disorders in the therapists (depression, substance abuse, Stockholm Syndrome, family problems etc)
vi) Self support groups (Balint groups) for the therapists where they can discuss cases and problems in confidence

This editorial therefore advocates for the inclusion of in-built programs for caring for the carers and for their continued support and training. In this issue of the AJTS, papers from various authors will present their experiences in trauma therapy in Africa and beyond.

Impact Of Conflict On The Psychological Wellbeing Of Health Workers In Liberia

Joy Turyahabwa[1]*, Ojiambo Ochieng R[2], Were-Ogutte J[2], Gayflor V[3], Howard Diawara L[4], Eugene Kinyanda[5]

[1]Department of Human Resource, Makerere University Business School, Kampala, Uganda.

[2]Isis-Women's International Cross Cultural Exchange (Isis-WICCE), Uganda.

[3]Ministry of Gender and Development of Liberia.

[4]Women in Peacebuilding Network (WIPNET/WANEP).

[5]MRC/UVRI Uganda Research Unit on AIDS.

Abstract

Background: *The 14 year Liberian civil war did not spare the health system including the psychological wellbeing of health workers. The extent to which the Liberian civil conflict did impact on the psychological wellbeing of the health worker is not known. The objective of this study was to examine the war trauma experiences and psychological wellbeing of 50 Liberian health workers who participated in Isis-WICCE pre medical intervention training conducted in 2009.*

Methodology: *Fifty health workers who were being trained to participate in a Isis-WICCE emergency medical intervention in post-conflict Liberia were assessed for their war trauma experiences and psychological problems using structured assessment tools.*

Results: *The most reported torture experiences included: loss of close relative as a result of war (68.0%), suffering beating/kicking (52.0%) and loss of property/ livestock through destruction and looting (84.0%).*

Psychological problems reported included: major depressive disorder (26.0%), PTSD (14.0%), alcohol dependency (8.2%) and 12-month attempted suicide (2.0%).

Conclusion: *Health workers assessed in this study suffered significant war trauma leading to psychological problems. The Ministry of Health and Social Welfare (MHSW) of Liberia should include psychological rehabilitation of the workforce in its human resource development plans in order to realize the workforce's full potential.*

AJTS JUNE 2011 2(1): 02-09

INTRODUCTION

The 14 year Liberian civil war from 1989-2003 did not only affect the population, it also severely affected the health system including the health workers (Ministry of Health and Social Welfare, 2007). This war led to disruption of health services: with health workers forced to flee into IDPs or to go to neighboring countries; health facilities were looted and vandalized; medical supplies becoming unavailable; and eventually government funding to the sector stopped leading to the total collapse of the country's health service (Ministry of Health and Social Welfare, 2007).

To rebuild this shattered health system, the Liberian Health Policy and Plan recognizes that developing a trained, educated and skillful workforce is a critical foundation for a quality health service (Ministry of Health and Social Welfare, 2007). What the Liberian Health Policy and Plan are silent about is the need for the psychological rehabilitation of this war traumatized health workforce in order to realize it's full potential.

Previous Isis-WICCE studies and/or interventions in both Uganda and Sudan have documented gross war torture experiences among health workers (Isis-WICCE, 2009). Sadly, in most conflict and post-conflict societies in Africa, the psychological wellbeing of the health workers is often never addressed or even mentioned. Health workers living and working in conflict and the post-conflict situations in Africa do so under extreme working conditions, are disadvantaged in terms of training opportunities and promotion, and are often left to deal with their traumas alone with many adopting maladaptive coping strategies including abuse of alcohol and other substances, absenteeism and in the extreme, engaging in suicidal behaviour all of which impair their ability to deliver health care to the population (Isis-WICCE, 2009).

This paper examines the war trauma experiences and psychological wellbeing of 50 Liberian health workers who participated in Isis-WICCE pre- medical intervention training conducted in the counties of Maryland and Grand Kru in 2009. The training was conducted to assess war trauma experiences and psychological problems of health workers living in conflict and post-conflict settings in Liberia.

The details of this Isis-WICCE medical intervention is described elsewhere (Isis-WICCE, 2009).

LITERATURE REVIEW

Health workers living and working in conflict and post-conflict settings may develop psychological problems as a result of three possible mechanisms: firstly, as a direct effect of war on the psychological wellbeing of the health workers; secondly, through their role as care givers (secondary trauma, vicarious traumatisation, burn out); and thirdly, through the poor working conditions in conflict/post-conflict situations.

***Correspondence:**

Joy Turyahabwa

Department of Human Resource, Makerere University Business School, Kampala, Uganda.

Direct effect of war on the psychological wellbeing of the health workers

As already observed, war does not spare the health worker; in some instances they may be particularly targeted as part of efforts to cripple a governments infrastructure. As previous Isis-WICCE studies and/or interventions in both Uganda and Sudan have documented health workers suffer gross war torture experiences such as this account by a health worker from Eastern Uganda (quoted from Isis-WICCE, 2009):

> *"at the height of the civil war in Teso, we were at a funeral vigil of someone who had been killed by rebels,… when all of a sudden rebels came into our midst… They ordered us to cook the corpse and forced us to eat it".*

Leibling-Kalifani and Baker (2010) in their study that involved interviewing health workers at Kitgum hospital in post-conflict northern Uganda observed that a number of health workers reported experiences of sexual violence and torture.

Health workers who have gone through such experiences develop the typical psychiatric syndromes associated with war trauma namely major depressive disorder, PTSD, alcoholism and suicidal behavior. These psychiatric syndromes do not only cause psychological distress in the health workers, they also interfere with their ability to help others. This is well illustrated by the results from the study by Leibling-Kalifani and Baker (2010) who observed that health workers from war affected Kitgum district hospital reported that listening to patient's traumatic experiences re-activated the health workers own traumatic experiences.

Secondary trauma, vicarious traumatisation and burn out

Working with clients who have suffered significant war trauma has been known to significantly affect the therapist's physical, psychological, emotional and/or spiritual wellbeing (Ingeborg, 2005; Pearlman & Saakvitne, 1995; Ajdukovic and Ajdukovic, 1998; Franciskovic et al, 1998). Three concepts have been used to describe this phenomena: these are 'compassion fatigue' (secondary traumatic stress), 'vicarious traumatization' and 'burnout' (Ingeborg, 2005; Pearlman & Saakvitne, 1995; Ajdukovic and Ajdukovic, 1998; Franciskovic et al, 1998).

'Compassion fatigue' describes the reduced capacity or interest in being empathic with subsequent behaviors and heightened uncomfortable emotions, resulting from knowing about a traumatic event experienced by a person (Ingeborg, 2005). 'Vicarious traumatization' refers to the acquisition of trauma responses due to close association with traumatized individuals (Pearlman & Saakvitne, 1995). 'Burnout' describes a process whereby trauma therapists are increasingly incapable of dealing with stress as result of feeling unable to meet the demands of work, their motivation in fulfilling their tasks declines, and in the end they suffer a state of exhaustion which can often last a very long time. A central factor in burnout is a sense of being unable to meet the demands of work (Ingeborg, 2005). Signs of burnout include: increased vigour in pursuing work objectives (initial sign); later followed by exhaustion, reduced work commitment, emotional reactions including assigning blame, diminishment, flattening, psychosomatic reactions and despair (Ingeborg, 2005).

Poor working conditions leading to psychological distress

Given the nature of war, health infrastructure very often suffers destruction, neglect and underfunding. Health workers operating in conflict and post-conflict situations therefore have to do with very difficult working situations which may lead to psychological distress. Leibling-Kalifani and Baker (2010) hospital had this to say:

> *"…health care staff described a lack of support, staff shortages, having to work long hours without breaks, and poor salaries and working conditions. They spoke of feelings of being exhausted and requested psychosocial support including trauma counseling for their own experiences. They described the overwhelming effects of hearing clients' traumatic stories which activated reminders of the staff's own experiences. This they said was made worse by the lack of support and opportunity to discuss these feelings".*

Which of these three mechanisms of psychological distress was operating in the Liberian health workers interviewed was not known and hence the need for this study.

METHODOLOGY:

50 health workers who were being trained from 21st-27th May 2009 to participate in a Isis-WICCE emergency medical intervention in post-conflict Liberia were assessed for their war trauma experiences and psychological problems. Prior to this assessment the objectives of the study were explained to the health workers and only those who consented to participate in the study were interviewed (100% consented, the health workers welcomed the idea to discuss for the first time their personal war experiences). This study as part of the bigger Isis-WICCE medical intervention obtained science and ethical approval from the Liberian Ministry of Health and Social Welfare. Health workers who were found in need of psychological and psychiatric help were treated by mental health specialists who were part of the training team.

Study tools

A structured questionnaires was self-administered to the respondents. It assessed for the following:

Socio-demographic characteristics: sex, age, religion, tribe, county and marital status.

Work related factors: post in hospital/health centre where working, duration of working in this health facility, monthly salary and whether this salary was sufficient to meet basic needs.

War torture experiences: Whether they had lost a close relative due to war, and ever suffered physical and psychological torture (Musisi et al, 2000).

Perpetrators of war torture: Using a structured proforma. Various domains of psychological distress were assessed, namely:

a) General health: Assessed by asking the respondents to rate their general health on a 1-5 scale, with one being the best and 5 the worst rating,

b) Major depressive disorder (MDD): This was assessed using the 15-item Hopkins Symptom Checklist (HSCL-25; Derogatis et al, 1974) where a cut-off point of 31 (previously calibrated by Kinyanda et al, 2009) was taken as indicative of probable MDD.

c) Post Traumatic Stress Disorder (PTSD): This was assessed using the Harvard Trauma Questionnaire (HTQ; Mollica et al, 2001) where a score of 28 and above was taken as indicative of probable PTSD.

d) Problem drinking of alcohol: This was assessed using the C.A.G.E (Ewing, 1984) with probable problem drinking taken as having any two positive items on this scale.

e) Attempted suicide: This was assessed by means of two questions: 'have you ever attempted to take your life? (by ingesting poison, hanging, taking a drug overdose, drowning, shooting) in the previous 12 months; and in your life-time?

Impairment of physical function: Assessed by a structured proforma.

Data management:

Data was entered into the computer and analyzed using the statistical package SPSS. Frequencies were generated and presented using tables.

Results:

Table 1, fifty (50) health workers of whom 28% were female got interviewed for this study. Most came from the counties of Maryland (40.0%) and GrandKru (54.0%). Most worked in clinics (46.9%) and health centres (38.8%). On age, most respondents were in the 26-35 years (40.0%) and the +46 years (32.0%) age groups and on tribe, the majority (72.0%) belonged to the Grebo.

Table 1: Types of Health facilities and characteristics of the health workers (N= 50)

	Total (N= 50)		Females (n=14)		Males (n=36)	
Variables	**N**	**%**	**n**	**%**	**n**	**%**
Type of health centre worked in						
Clinic	23	46.9	5	35.7	18	51.4
Health centre	19	38.8	5	35.7	14	40.0
Government Hospital	6	12.2	3	21.4	3	8.6
Private Hospital	1	2.0	1	7.1	0	0.0
County						
Maryland	20	40.0	6	42.9	14	38.9
Grand Kru	27	54.0	6	42.9	21	58.3
Lofa	1	2.0	1	7.1	0	0.0
Bong	2	4.0	1	7.1	1	2.8
Age groups						
26-35 yrs	20	40.0	5	35.7	15	41.7
36-45 yrs	14	28.0	5	35.7	9	25.0
+46 yrs16	16	32.0	4	28.6	12	33.3
Tribe						
Kpelle	1	2.0	1	7.1	0	0.0
Bassa	1	2.0	0	0.0	1	2.8
Kru	3	6.0	2	14.3	1	2.8
Grebo	36	72.0	9	64.3	27	75.0
Mano	1	2.0	0	0.0	1	2.8
Mandingo	1	2.0	1	7.1	0	0.0
Lorma	1	2.0	0	0.0	1	2.8
Kissi	2	4.0	1	7.1	1	2.8
Krahn	1	2.0	0	0.0	1	2.8
Other	3	6.0	0	0.0	3	8.3

Other tribes: Bakrobo (1), Bandi (1), Vai (1)

Table 2, on religion the majority (60.0%) belonged to the Christian 'saved sect' while on marital status, most (40.0%) were in monogamous married/cohabiting relationships. On highest educational attainment most health workers in this study had either a senior 5-6 level (40.0%) or a tertiary/university level (38.0%) educational attainment.

Table 2: Religion, marital status, highest level of education of health workers (N=50)

	Total (N= 50)		Females (n=14)		Males (n=36)	
Characteristics	**N**	**%**	**n**	**%**	**n**	**%**
Religion						
Protestant	7	14.0	1	7.1	6	16.7
Catholic	11	22.0	4	28.6	7	19.4
Christian saved sect	30	60.0	8	57.1	22	61.1
Moslem	1	2.0	1	7.1	0	0.0
Other	1	2.0	0	0.0	1	2.8
Marital status						
Never married	13	26.0	5	35.7	8	22.2
Married/cohabiting (Monogamous relationship)	23	46.0	5	35.7	18	50.0
Married cohabiting (polygamous relationship)	8	16.0	1	7.1	7	19.4
Widowed	3	6.0	3	21.4		
Divorced/Separated	3	6.0	0	0.0	3	8.3
Highest level of education						
Primary level	5	10.0	1	7.1	4	11.1
Senior 1-4	6	12.0	2	14.3	4	11.1
Senior 5-6	20	40.0	3	21.4	17	47.2
Tertiary/University	19	38.0	8	57.1	11	80.6

Table 3, on duration of work, most (70.0%) had been working at their job for more than 3years (+36 months). On salary, most respondents earned Liberian dollars, between 2001-5000 (44.0%) and 5001-15,000 (34.0%) with nearly all (96.0%) of them reporting that the salary they were getting was not sufficient to meet their basic requirements.

Table 3: Duration of work(months) and salary (N= 50)

	Total (N= 50)		Females (n=14)		Males (n=36)	
Characteristics	**n**	**%**	**n**	**%**	**N**	**%**
Duration of work						
≤ 12 months	6	12.0	2	14.3	4	11.1
13-24 months	6	12.0	2	14.3	4	11.1
25-36 months	3	6.0	3	21.4	0	0.0
+37 months	35	70.0	7	50.0	28	77.8
Salary(Liberian Dollars)						
≤ 2000	4	8.0	1	7.1	3	8.3
2001-5000	22	44.0	5	35.7	17	47.2
5001-15000	17	34.0	7	50.0	10	27.8
Missing	7	14.0	1	7.1	6	16.7
Salary sufficient to meet my basic needs						
Yes	2	4.0	1	7.1	1	2.8
No	48	96.0	13	92.9	35	97.2

Table 4, on loss of close relative as a result of war, most respondents (68.0%) reported that they had lost at least one close relative as a result of war, 10.0% had lost a spouse (more among female than male respondents) and 16.0% had lost a child/children.

Table 4: Relatives who died in the war (N= 50)

	Total (N= 50)		Females (n=14)		Males (n=36)	
Characteristics	**n**	**%**	**n**	**%**	**N**	**%**
Lost spouse	5	10.0	3	21.4	2	5.6
Lost child/children	8	16.0	3	21.4	5	13.9
Lost other relatives	34	68.0	10	71.4	24	66.7

Table 5, the most reported physical torture experiences included: beating/kicking (52.0%), deprivation of food/water (48.0%) and forced hard labour (42.0%) all reported more by males than females. The most reported psychological methods of war torture included: loss of property/livestock through destruction and looting (84.0%), detention by the army (68.0%), and forced to sleep in the bush/swamps (70.0%). All these psychological methods of torture were reported by both females and males in equal proportions.

Table 5: Experienced war torture (N= 50)

	Total (N= 50)		Females (n=14)		Males (n=36)	
Characteristics	**n**	**%**	**n**	**%**	**N**	**%**
Physical methods of torture						
Beating/Kicking	26	52.0	2	14.3	24	66.7
Bayonet/Knife/Panga/Spear injuries	5	10.0	0	0.0	5	13.9
Forced hard labour	21	42.0	3	21.4	18	50.0
Severe tying(Kandoya)	9	18.0	1	7.1	8	22.2
Deprivation of food/water	24	48.0	4	28.6	20	55.6
Deprivation of medicine	20	40.0	3	21.4	17	47.2
Cutting of body parts	4	8.0	1	7.1	3	8.3
Gunshot/landmine injury	10	20.0	2	14.3	8	22.2
Burning	5	10.0	1	7.1	4	11.1
Psychological torture						
Detained by the army	34	68.0	9	64.3	25	69.4
Forced to sleep in the bush/swamp	35	70.0	10	71.4	25	69.4
Being abducted	9	18.0	3	21.4	6	16.7
Losing property/livestock through destruction and looting	42	84.0	12	85.7	3.0	83.3
Losing property/livestock through destruction and looting Forced to join the arm or rebel ranks against your will	6	12.0	0	0.0	6	16.7
Being forced to kill someone against your will	1	2.0	0	0.0	1	2.8

Tables 6, the main perpetrators of war torture among this group were the rebel groups (68.0%) and government soldiers (44.0%). Both groups were equally reported by both genders.

Table 6: Perpetrators of war torture(N= 50)

	Total (N= 50)		Females (n=14)		Males (n=36)	
Characteristics	**n**	**%**	**n**	**%**	**N**	**%**
War perpetrator						
Government soldiers	22	44.0	6	42.9	16	44.4
Rebel groups	34	68.0	10	71.4	24	66.7
Police	5	10.0	0	0.0	5	13.9
Local militia	12	24.0	1	7.1	11	30.6
Prison officers	3	6.0	0	0.0	3	8.3

Table 7, on physical wellbeing and psychological health, most respondents (72.0%) reported that their health was good to very good with more females (85.7%) than males (66.7%) reporting this. On psychological problems, 26.0% had scores suggestive of depression more among females (28.6%) than males (25.0%), while 14.0% of respondents had scores suggestive of PTSD significantly more among females (21.4%) than males (11.1%). Other psychological problems reported mainly among males were alcohol dependency (8.2%) and attempted suicide (2.0%).

Table 7: Physical and psychological wellbeing of respondents a (N=50)

	Total (N= 50)		Females (n=14)		Males (n=36)	
Characteristics	**n**	**%**	**n**	**%**	**N**	**%**
General health						
Excellent	3	6.0	0	0.0	3	8.3
Very good	15	30.0	5	35.7	10	27.8
Good	21	42.0	7	50.0	14	38.9
Fair	8	16.0	1	7.1	7	19.4
Poor	3	6.0	1	7.1	2	5.6
Psychological problems						
Have depression (Hopkins scale score of least 31)	13	26.0	4	28.6	9	25.0
Have PTSD (HTQ) (score of at least 28)	7	14.0	3	21.4	4	11.1
Alcohol dependency (CAGE positive)	4	8.2	0	0.0	4	11.4
Attempted suicide (last 12 months)	1	2.0	1	7.1	0	0.0

Table 8, About one tenth of the health workers reported that they were impaired in their physical (14.0%) and in their professional work (16.0%) as a result of the psychological symptoms they were experienced. The impairment in physical work was reported more by females (28.6%) than males (8.3%), with no gender differences observed on impairment of professional work (16%).

Table 8: Degree of impairment of the health workers (N= 50)

	Total (N= 50)		Females (n=14)		Males (n=36)	
	n	**%**	**n**	**%**	**N**	**%**
Impairment in:						
Vigorous activity (digging in the garden, lifting heavy objects)	7	14.0	4	28.6	3	8.3
Professional work (helping and treating patients)	8	16.0	2	14.3	6	16.7

DISCUSSION/RECOMMENDATIONS:

Like has previously been reported in conflict and post-conflict settings in Africa and elsewhere in the world (Isis-WICCE, 2009; Ajdukovic and Ajdukovic, 1998; Franciskovic et al, 1998), Liberian health workers who were assessed in this study reported that they had suffered various forms of war torture. The war torture experiences included both physical and psychological torture experiences. The main perpetrators of these abuses on the health workers were the main protagonists of the Liberian civil war, (the rebels and government soldiers). These war tortures left psychological scars on these health workers as reflected by those who had depression, PTSD, alcohol dependency and attempted suicide as has been observed elsewhere in the world (Ingeborg, 2005; Pearlman & Saakvitne, 1995; Ajdukovic and Ajdukovic, 1998; Franciskovic et al, 1998). These psychological scars were in 16% of cases impairing the professional functioning of the health workers. Work related factors could also be imputed to affect the psychological wellbeing of the health workers as only 4% of the health workers reported getting a salary that would satisfy their basic living requirements.

For recommendations, the Ministry of Health and Social Welfare (MHSW) of Liberia should include psychological rehabilitation of the health and other workforce in its human resource development plans in order to realize the workforce's full potential. Secondly, the MHSW should work towards providing health workers with a living wage to reduce psychological distress associated with the daily struggle of making ends meet. Thirdly, there is need for bigger studies in order to be able to generalize research findings from this study to the wider body of health workers in Liberia.

REFERENCES:

1. Ministry of Health and Social Welfare (2007) : National Health Policy, National Health Plan 2007-2011. Monrovia, Liberia.

2. Isis-WICCE (2009): Touching the unreached: A medical intervention in Liberia. A report by Isis-WICCE in conjunction with the Ministry of Health & Social Welfare, Liberia and Ministry of Gender and Development, Liberia and WANEP/WIPNET, Liberia. Kampala, Uganda.

3. Liebling-Kalifani H, and Baker B. (2010): Justice and health provision for survivors of sexual violence in Kitgum, northern Uganda. African Journal of Traumatic Stress, 1(1):23-33.

4. Ingeborg J. (2005): Stress and risk factors resulting from confrontation with trauma of war-related sexualized violence in a professional context. In (ed.) Medica Mondiale. Violence against women in war: Handbook for professionals working with traumatized women, pp. 194-218. Cologne, Germany.

5. Pearlman LA, & Saakvitne KW (1995): Trauma and the therapist. Countertransference and vicarious traumatisation in psychotherapy with incest survivors. New York, USA.

6. Ajdukovic M, & Ajdukovic D. (1998): Mental health care for helpers: Experiences from a training programme. In (ed.) Libby Tata Arcel, War violence, trauma and the coping process. pp. 314- 318. Nakladnistvo Lumin, Croatia.

7. Franciskovic T, Pernar M, Moro L, Roncevic-Grzeta I. (1998): Aggravating and mitigating factors in the development of the "Burn-out" syndrome. In (ed.) Libby Tata Arcel, War violence, trauma and the coping process. pp. 319-325. Nakladnistvo Lumin, Croatia.

8. Musisi S, Kinyanda E, Leibling H, Mayengo K. (2000): Posttraumatic torture disorders in Uganda- A three year retrospective study of patient records as seen at a specialized torture treatment center in Kampala, Uganda. Torture, 10(3): 81-87.

9. Derogatis LR, Lipman RS, Rickels K, Uhlenhuth EH, Covi L. (1974): The Hopkins symptom checklist (HSCL): a self report symptom inventory. Behavioural Science 19 (1): 1-15.

10. Kinyanda E, Woodburn P, Tugumisirize J, Kagugube J, Nyanabangi S, Patel V. (2009): Poverty, life events and the risk for depression in Uganda. Social Psychiatry & Psychiatric Epidemiology DOI: 10.1007/s00127-009-0164-8.

11. Mollica RF, Caspi-Yavin Y, Bollini P, Truong T, Tor S, Lavelle J. (1992): The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma and post-traumatic stress disorder in Indochinese refugees. Journal of Nervous and Mental Disease 180(2):110-115.

12. Ewing JA. (1984): Detecting alcoholism. The C.A.G.E. questionnaire. Journal of the American Medical Association, 252 (14) 7: 1905-7.

Refugees And Mental Health Care In Africa: What Can Be Done?

Sebit, MB
Department of Psychiatry and Mental Health, Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania.

Abstract
Political turmoil in Africa shows no sign of abating and conflicts continue to erupt. Since the 1950s, many nations in Africa have suffered civil wars and ethnic strife, thus generating massive numbers of refugees of many different nationalities and ethnic groups. These refugees are at a high risk of contracting communicable and non-communicable diseases including mental health problems. Often, they lack adequate medical and mental health care. The question then, is how to design a strategic approach to address the many mental health problems faced by the multitude of refugees as well as their general healthcare. This paper aims to review the literature on the current mental health care of refugees in Africa and to make recommendations. The author used data sources from published studies, broad searches of computerized databases and manual searches of reference lists. The paper analyses this literature and attempts to throw light on some of the challenges that refugees pose for mental healthcare. Finally the paper discusses alternative strategies to address the pertinent mental health issues including access to the mental healthcare and the often encountered inequalities in the provision of care.
AJTS JUNE 2011 2(1): 10-16

INTRODUCTION

Who Is A Refugee?

A refugee is a person who has been forced to leave their home country and seek sanctuary elsewhere. Under the United Nations Convention relating to the Status of Refugees of 1951, a refugee is more narrowly defined in Article 1A as a person who «owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his/her nationality, and is unable to go back or, owing to such fear, is unwilling to avail him/herself of the protection of that country» (UNHCR, 2010). The concept of refugee-ship was expanded in the Convention's 1967 Protocol and by the regional conventions in Africa and Latin America to include persons who had fled war or other violence in their home country.

History

Historically, refugees are not a recent phenomenon. The notion that a person who sought sanctuary in a holy place could not be harmed without inviting divine retribution was familiar to the ancient Greeks and ancient Egyptians. The right to seek asylum in a church or other religious place was first codified into law by King Ethelbert of Kent in about 600 A.D. Similar laws were implemented throughout Europe in the Middle Ages. The related concept of political exile also has a long history as in the story of Ovid who was sent to Tomis, or Voltaire who was sent to England. The 1648 Peace of Westphalia treaty made nations to recognize each other's sovereignty and to use the phrase 'country of nationality'. It required people crossing borders to provide identification (Wikipedia, the free encyclopaedia, 2010). However, in times of strife e.g. war, such identifications were impossible to provide hence creating the notion of refugee-ship.

Globally, by 2002 there were 18 million refugees (Tribe, 2002). The number of people affected by wars has increased considerably in the last decades and these cause the greatest number of refugees. Summerfield (2000) claimed that nearly 1% of the people in the world were refugees or displaced persons resulting from about 40 violent conflicts. Most of these are in Africa. For example, an estimated 2.5 million people of the Darfur area have been forced to flee their homes after attacks by Janjaweed Arab militias backed by Sudanese government troops since 2003 (Bloomfield, 2007). The term «refugee» as used in this paper includes asylum seekers, conventional refugees, internally displaced peoples and repatriated persons, as well as other non-displaced populations but affected by war or organised violence.

Objectives

The main purpose of this paper will be to review the literature on the mental health care of refugees in Africa in order to throw light onto the experiences and challenges faced by these refugees and to discuss their possible mental healthcare. The data sources are published studies using broad searches of computerized databases, published articles and manual searches of reference lists.

Correspondence:
Sebit, MB
Department of Psychiatry and Mental Health, Muhimbili University of Health and Allied Sceicnes, Dar es Salaam, Tanzania.
E-mail: mb.sebit@mnh.or.tz

Refugees In Africa

Africa was partitioned out into European-owned colonies in 1884, along which lines the newly independent African nations of the 1950s and 1960s drew their borders. These borders divided families, communities, ethnic groups and natural nation-states or fiefdoms. They lumped together previously antagonistic nation-states and divided others which were getting along well. The partitioning of Africa only suited European interests and did not consider African concerns. It introduced new language blocks where none existed before for example Anglophone, Francophone or Portuguese speaking Africa and others. The 1884 Berlin Conference that divided Africa has been cited as the major reason why today's Africa has been so plagued with warfare. The number of refugees in Africa increased from 860,000 in 1968 to 6,775,000 by 1992 (Refugee, 2004). Given the magnitude of the problem and the lack of resources, mental health care has been minimal, for example the case of Burundi and Rwandan refugees, in Tanzania (Jong et al, 2000) or the internally displaced peoples in Uganda's IDP camps (Musisi et al, 2005).

Unlike survivors of most discrete traumatic events, refugees experience diverse stressors that accumulate over the pre-flight, flight, exile, and resettlement/ repatriation periods (Martin, 1994). These issues include the causes of the wars, human rights abuses or persecutions on grounds of politics, religion, gender or ethnicity. The victims suffer numerous losses including loss of country, culture, family, profession, language, friends, and plans for future. In addition to these losses are other issues in the country of asylum such as multiple changes in lifestyle, psychological and practical adjustment, uncertain future, traumatic life events, hardship, discrimination, racism, stereotyping by host communities and a host of undocumented cultural traditions (Tribe, 2002). They may also suffer new diseases including malaria, cholera, dysentery, HIV/AIDS and many others for a variety of reasons including overcrowding, unsanitary living conditions, exposure to the elements and many others.

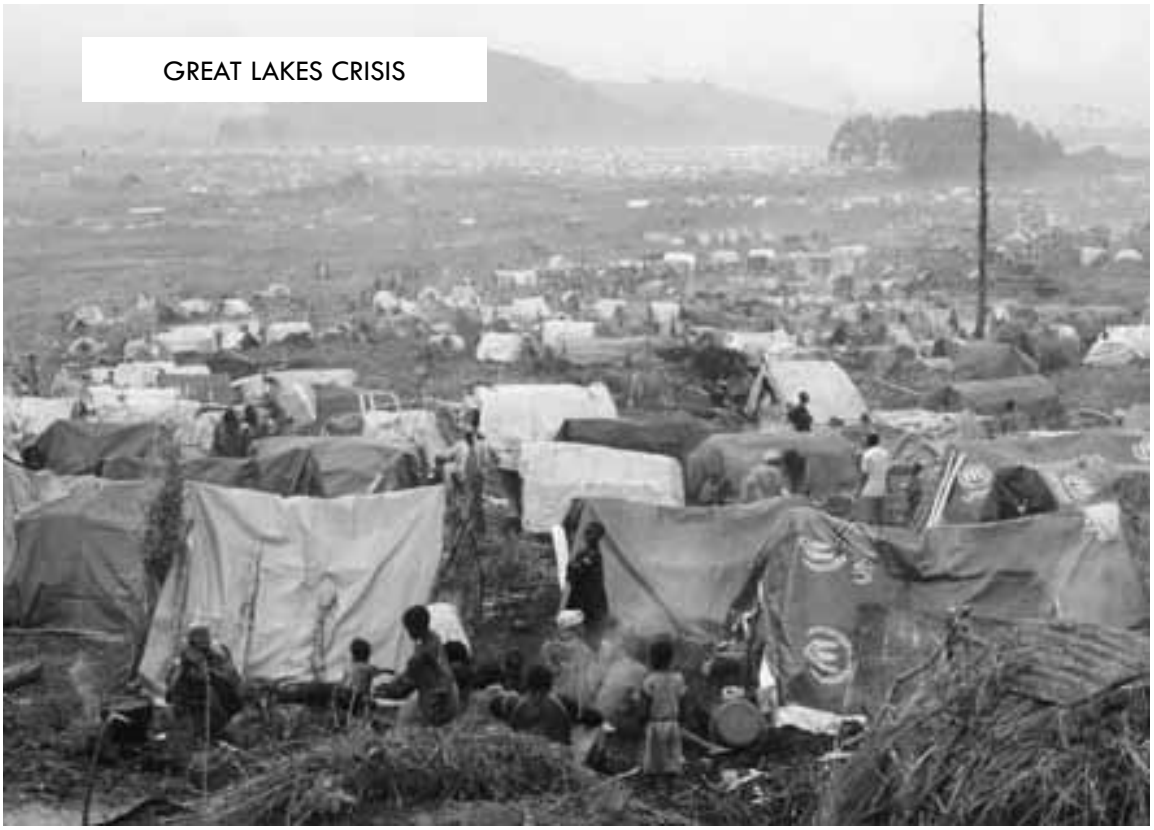


Figure I: A Refugee settlement in the African Great Lakes Region

Source: UNHCR

Mental Health Problems And Refugees

The development of mental disorders or behavioural abnormalities depends on the interaction between the individual and bio-psycho-social factors. On average, more than 50 per cent of refugees present with mental health problems ranging from chronic mental disorders to trauma, distress and a great deal of suffering and misery. No matter the causes, but within a limited period of time and more often suddenly, millions of people get forcibly displaced with no preparations or warning (Petevi, 1996). As a result, these refugees become vulnerable to multiple dimensions of psychopathology beyond those that are narrowly defined as Post-traumatic Stress Disorder or PTSD (Hollifield et al, 2002; Marsella et al, 1996). In one study, Eisenman et al (2003) showed that among Latino refugees who had been exiled in the USA after exposure to political violence, 36% had symptoms of depression and 18% had symptoms of PTSD compared to those who had not been exposed to political violence whose rates were lower at 20% and 8%, respectively. In their study of the Senegalese refugee population, Tang and Fox, (2001) found high rates of anxiety, depression and post-traumatic stress disorder signifying a complex humanitarian crisis with Rape Trauma Syndromes (Sebit and Kilonzo (2010). Musisi et al (2005) has described the multiplicity of mental health problems in African populations displaced by war from their home environments. Socioeconomic status, educational background, and gender all affect levels of mental illness in refugees (Porter and Haslam, 2005). Substantial evidence indicates that social position also plays a major role in the development of mental health disorders among refugees (Holzer et al, 1986). It also plays a role in their service utilisation (Alegria et al, 2000). Similarly, the environmental context is crucial in the variations in the mental disorders and access to health care (MacIntyre et al, 1993). However, refugees are also known survivors who possess amazing resiliency, strength and resourcefulness (Minnesota, 2011).

Challenges In Providing Mental Healthcare To Refugees.

The biggest challenge to refugee mental health care in Africa is the big burden of refugees and yet with a lack of resources (Musisi et al, 2004 & 2005). Sub-Saharan African countries are characterized by low incomes, high prevalence of communicable diseases and malnutrition, low life expectancy and poorly staffed services (UNDP, 1995; World Bank, 1998). For instance, lack of infrastructure, inadequate skills and poor support and training undermine successful implementation of mental health care in most parts of Southern Africa (Burns, 2008). Mental health issues often come last on the list of priorities for policy makers (Desjarlais, 1995).

Secondly, there is a lack of awareness of the magnitude of the mental health problems due to non-existence of epidemiological data in most of the Sub-Saharan African countries or due to pure ignorance of mental health issues (Musisi et al, 2005). In normal circumstances, patients with mental illness are easily marginalized by the social services, including mental health care services. Also, there is a lack of reliable information systems. The role played by traditional and faith healers often dictates mistrust of Western treatments for mental illness and often advocates strongly against any medication intake, in preference for other rituals and prayers, thus constituting an obstacle rather than an asset to mental healthcare provision. Moreover, refugees often face cultural, religious, gender, age, economic and social barriers in their attempts to accessing mental health care. Unequitable access to cost-effective mental and psychosocial care often contributes to the difficulties faced by refugees. This includes language barriers, cultural differences and differences in the interpretation of the meaning or explanations of

the symptoms of mental illness (Bohnlein, 2001). Poor commitment by governments, health workers and the community at large to mental heath issues, also impairs care provision, often based on lack of awareness of mental illness.

What Can Be Done To Provide Better Refugee Mental Healthcare Systems?

Just as there is no health without mental health, there is no equality without mental health equality. Mental health has been described by the World Health Organisation (WHO, 2009) as: "... a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." Consequently, the shortage of money, staff and facilities make unequal access to care. Health equity is about the way the available resources are distributed. Future health campaign programs need to emphasize the fact that not providing mental health care is costly. There is a need to find a balance between helpful traditional and faith healing practices and the scientific evidence-based modern mental health care to avoid alienating the affected peoples (Makanguola, 2003).

Given the impact of war on large populations in Africa, care on an individual basis is not realistic. A community-based psychosocial rehabilitation which is integrated in the Primary Health Care services creates more sustainable responses (Musisi et al 2004). At the earliest possible opportunity, people with mental health disorders and severe psycho-trauma should be identified and treated. Indigenous methods of coping
and psychological therapy can be integrated
within Western methods of therapy to provide a wide spectrum of mental health care and help to the affected refugees (Mercer et al, 2005). These have included both traditional and faith-based practices. Examples of such initiatives are abound worldwide. For instance, religion has provided Tibetans with an explanation for their situation and hope for a better future (Sachs et al, 2008). Non-mental health personnel, given appropriate technical support, have proven efficient in responding to the psychosocial distress of refugees. Given the paucity of expert mental health workers in Africa, task shifting in the provision of mental health care is highly recommended (Manas model). Whatever the mental health initiatives, they must be based on the core principles of universal respect to Human Rights, non-discrimination and universal accessibility of care to all without prejudice. Age and gender specific programs must be integrated in the care provision.

Inequalities in mental health care provision should be addressed by an appropriate strategy and allocation of resources. Governments must be encouraged to have post-conflict mental health care policies followed by corresponding legislation. This ensures strengthening and monitoring of the capacity of governments to ensure equitable financing and delivery of priority public health including mental health care services, especially to marginalized and underserved populations including refugees. Greater international cooperation and information exchange will remedy the chaos of crisis situations. There is a need to regulate and co-ordinate NGO initiatives, both local and international. This avoids duplication and redundancy as well as undermining local efforts or ignoring traditional care systems. There is also a need to increase the effectiveness of research-to-policy linkages in promoting the dual goals of health and social equity in order to achieve socio-economic development and to complement clinic-based treatments with a wide range of community-based initiatives, which are viewed as more culturally acceptable and which improve the welfare of the refugees (Miller 1999).

It is important that healthcare facilitators be recruited from each specific refugee population, especially due to language and other possible cultural barriers. These help to provide patient records with accurate, reliable and detailed medical history and to support health promotion and screening activities. There should be training of humanitarian aid workers on human rights and basic mental health skills such as active listening, cultural sensitivity, trauma management, community-based activities and community empowerment. Provisions should be made for recreational and cultural space in the design of refugee camps, e.g.,
playgrounds, sports fields, places for religious and cultural ceremonies and other community activities. Finally it is important to establish and maintain a flow of reliable information and making it available to the concerned communities.

Suggested Durable Solutions To The Fate Of Refugees

These include, but are not limited to, the following:

- Voluntary repatriation to home country. For example, more than 353,000 Burundian and 60,000 Congolese camp refugees have been assisted to return home [by UNHCR] from the camps since 2002 and 2005 respectively. This has also happened in Rwanda and Uganda. The International Organization for Migration (IOM/OIM) helps play an important role in this.
- Local integration into the country of first asylum for the final integration of the newly naturalized individuals needs to be facilitated and monitored to ensure their smooth transition and socio-economic integration in the regions of final destination. Tanzania has provided the best example of this naturalization of refugees on the African continent.
- Resettlement in a third country or elsewhere. This ensures access to asylum procedures and international protection for all people of concern, including those arriving in mixed-migration flows. It calls for the development of the asylum capacity of the Governments and to advocate for the creation of institutional arrangements to enable border officials to identify and document people of concern.

Conclusion

This paper addressed and underlined an urgent need for action to augment access to mental healthcare care for refugees as well as the more relevant factors underlying inequality in refugee mental health that should be addressed. Refugees and poor people generally are much more at risk of having mental health problems compared to non-refugees or people who are not poor (Myles et al, 2005: Hauck and Rice, 2004). One may argue that refugee families are not likely to have enjoyed good quality primary mental health care in their countries of origin. However, the crux of the matter is the fact that refugee populations are likely to remain large and refugee-ship is stressful, thus creating vulnerable at risk populations for mental illness. Inequality does exist in mental healthcare provision, coming largely out of factors external to it. A truly effective solution requires the political will from recipient governments to develop a comprehensive strategy at national level. It requires multi-sectoral approaches in development and implementation of responses between many professions within different ministries, NGOs, academic and research settings. Refugees are a vulnerable group and a strict ethical code should govern research into this population. It is incumbent upon all mental health professionals to lobby governments for the provision of the necessary resources to fostering resilience among refugees, restore their dignity and give them hope and confidence. This calls for reforms to the mental health care systems currently prevalent in most Sub-Saharan African countries pointing to the need to continue to explore improvement in African mental healthcare systems in order to promote equitable access to mental health care services by all including refugees.

References

1. Alegría M, Bijl R, Lin E, et al (2000): Income differences in persons seeking outpatient treatment for mental disorders: a comparison of the US with Ontario and the Netherlands. Archives of General Psychiatry 57:383-391.

2. Bloomfield, S (2007): Arabs pile into Darfur to take land 'cleansed' by janjaweed, The Independent, Africa, July 2007

3. Burns, jk (2008): Implementation of the Mental Health Care Act (2002) at district hospitals in South

Africa: Translating principles into practice. S Afr Med J. 98(1):46

4. Desjarlais, R (1995): World mental health: problems and priorities in low-income countries. New York: Oxford University Press.

5. Eisenman, DP; Gelberg, L; Liu, H; PhD; Shapiro, MF (2003): Mental Health and Health-Related Quality of Life Among Adult Latino Primary Care Patients Living in the United States With Previous Exposure to Political Violence. JAMA. ;290:627-634.

6. Hauck, K., Rice, N. (2004): A longitudinal analysis of mental health mobility in
Britian, Health Economics, 13, p.981-1001.

7. Hollifield M, Warner TD, Lian N, et al (2002) : Measuring trauma and health status in refugees: a critical review. JAMA ;288:611-621

8. Jong, JP de, Scholte WF, Koeter MWJ, Hart AAM (2000): The prevalence of mental health problems in Rwandan and Burundese refugee camps. Acta Psychiatr Scand, 102(3):171-177

9. Makanjuola, AB (2003): A cost comparison of traditional and orthodox mental health care. Niger Postgrad Med J. Sep;10(3):157-61

10. MacIntyre S, MacIver S, Sooman A (1993): Area, class, and health: should we be focusing on places or people? Journal of Social Policy 22:213-234.

11. Marsella AJ, ed, Friedman MJ, ed, Gerrity ET, ed, Scurfield RM, ed (1996): Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research and Clinical Applications. Washington, DC: American Psychological Association; 1996.

12. Mercer et al (2005): Psychosocial distress of Tibetans in exile: integrating western interventions with traditional beliefs and practice. Soc Sci Med; 2005(1): 179-189

13. Tang,SS and Fox,S; Steven H (2001): Traumatic Experiences and the Mental Health of Senegalese Refugees. Journal of Nervous & Mental Disease. 189(8):507-512.
Holzer CE, Shea BM, Swanson JW, et al (1986): The increased risk for specific psychiatric disorders among persons of low socioeconomic status. American Journal of Social Psychiatry 20:259-271

14. Porter, M. and Haslam, N. (2005): Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons. JAMA;294(5):602-612.

15. Miller, K. (1999): Rethinking a familiar model: psychotherapy and the mental health of refugees. Journal of Contemporary Psychotherapy, 29, 283–306.
Minnesota Refugee Health Provider Guide, 2011-08-18; (www.health.state.mn.us/refugee)

16. Myles, F., McCollan, A., Woodhouse, A. (2005): National Programme for Improving Mental Health and Wellbeing: Addressing Inequality in Mental Health in Scotland: Equal Minds, Scottish Centre for Mental Health, Scottish Executive, Edinburgh

17. Petevi M, Forced Displacement (1996): Refugee Trauma, Protection and Assistance. In International Responses to Traumatic Stress, Danieli Y, Rodney N, and Weisaeth L, (Eds). United Nations Publication, Baywood Publishing Company, New York 1996.

18. Refugee, Encyclopedia Britannica, 2004

19. «refugee, n.». Oxford English Dictionary Online. November 2010. http://www.oed.com/viewdictionaryentry/Entry/161121. Retrieved 23 February 2011.

20. Rogers, A., Pilgrim, D. (2003): Mental health and Inequalities, Palgrave Macmillan, Basingstoke

21. Sachs et al. (2008). Entering exile: Trauma, Mental Health and Coping among Tibetan Refugees Arriving in Dharamsala, India. J. Trauma Stress : 199-208

22.Sebit, MB and Kilonzo, G. Rape Trauma Syndrome. Chapter pp. 271-276. The Aspects of Mental Health. Mension Publishers' Haarlem (2010).

23.Summerfield, D. (2000): War and mental health: a brief overview. BMJ, 321, 3323–3325.

24.Tribe, R. (2002): Mental health of refugees and asylum-seekers Advances in Psychiatric Treatment (2002) 8: 240-247

25.UNITED NATIONS DEVELOPMENT PROGRAM (1995). Human Development Report. Geneva: United Nations.WORLD BANK (1998): African Development Indicators 1998/99. Washington: World Bank.

26.UNHCR (2002): UNHCR Mission Statement. Geneva: UNHCR.

27.UNHCR. http://www.unhcr.org.au/basicdef.shtml. Retrieved 19 June 2010.

28.Wikipedia® is a registered trademark of the Wikimedia Foundation, Inc., a non-profit organization. This page was last modified on 25 August 2010.

29.WHO. WHO/UNHCR Mental Health of Refugees. WHO, Geneva 1999: 4. WHO. Declaration of Cooperation in Mental Health of Refugees and Internally Displaced Populations in Conflict and Post-Conflict Situations, Ed. Petevi M, WHO, Pre-final draft, Geneva 1999.

30.Musisi S. (2004): Mass Trauma and Mental Health in Africa. African Health Sciences Journal. Vol.4 No. 2 Aug 2004

31.Musisi S (2005): War and Mental Health In Africa. In Essentials Of Clinical Psychiatry For Sub-Saharan Africa. F. Njenga, W. Acuda ,V. Patel & M.Maj (Eds) Masson Publications. Milano, Italy.

32.Boehnlein JK. (2001): Cultural Interpretations of Physiologic Processes in Post-Traumatic Stress Disorder and Panic Disorder. Trans-culturalPsychiatry Vol. 38(4):461-467.

Needed – Not Just Needy: Empowerment As A Therapeutic Tool In The Treatment Of Survivors Of Torture And Refugee Trauma

Hawthorne E. Smith[1]* **and Adeyinka M. Akinsulure-Smith****
*Bellevue/NYU Program for Survivors of Torture.
**City College of New York, City University of NewYork

Abstract

Many Africans and others from all over the world, go to America, fleeing torture and other forms of organized violence from their home countries. Not only do many of these displaced people face culture shock, but the process of exile and application for asylum seeking often proves a big challenge and traumatic experience in itself. Yet many continue to suffer and also have to deal with the repercussions of their experiences. This paper presents the therapists' views and experiences in treating exiled asylum seekers in New York City, many of whom are from Africa.

The paper reviews the 'Introduction/Initiation' phase to therapy to engagement of the client, the challenges faced by both the therapist and the client, the theoretical and philosophical rationale for the therapy, the techniques used, the process of therapy itself including group process, and finally the outcome of therapy. Actual case scenarios are presented with deep understanding of the dynamics involved and the humility and patience of the experienced therapist(s). The paper concludes by emphasizing the power of "empowerment of clients" to facilitate and enhance the (African) torture survivor to take charge and utilize his/her inherent strengths to engage in treatment for a better future of hope.
AJTS JUNE 2011 2(1): 17-31

INTRODUCTION

The "Rip Up Exercise"

When presenting information regarding clinical work with survivors of torture and refugee trauma to service providers, we have found it useful to initially engage them in a brief experiential exercise. The facilitator asks each member of the group to write the "five most important things in the world" to them. These should be five precious things that "make life worth living" in an emotional sense, and do not have to be "things" in the strictest sense of the word. The facilitator waits a few minutes for the responses, and then collects the papers.

The facilitator then moves on to describing the multiple losses associated with torture and refugee trauma. Without divulging names, or identifying who wrote what, the facilitator reads through some of the responses from the papers he or she has collected. Often, audience members will write down the names of family members or loved ones. They may name a relationship such as marriage. Respondents may mention material things and possessions, such as an ancestral home. Other responses may describe aspirations (i.e. obtaining an advanced degree), passions (i.e. playing or enjoying music), achievements (i.e. professional success), or a general sense of well-being (i.e. good health, freedom, etc.).

After reading through a number of these responses, the facilitator rips all of the papers to shreds. He or she then asks the audience to imagine for a moment that all of these precious things have been taken from them through violent means, and that they are currently powerless to reclaim any of them. This symbolizes the painful scenario that survivors of torture and refugee trauma who are now living in exile are facing (Akinsulure-Smith, Smith & Van Harte, 1997; Smith & Keller, 2007, p.5).

Studies have shown that the additional stressors of refugee trauma serve to exacerbate psychological sequelae of torture and other human rights abuses (Quiroga & Jaranson, 2005). The literature states that it may not be migration itself that causes the increased symptomatology for refugees, but the severe stress of the migration under harrowing circumstances, and the multiple levels of disempowerment and insecurity faced in the new environments (Berliner et al., 2004; Den Velde, 2000). Pre-migration stressors were found to be important predictors of mental health functioning (Bhui et al., 2003; Lie, 2002; Silove et al., 1997), and post-migration stressors were found to have significant effects on psychological functioning (Jaranson et al., 2004; Lie, 2002; Roth & Ekblad, 2002; Silove et al., 1997; Somnier, Vesti, Kastrup, & Genefke,1992; Thomas & Thomas, 2004).

Objective

This paper presents a discussion of the experiences of therapists in the treatment of exiled (African) survivors of torture and other forms of organized violence (often wars), who are seeking asylum in USA as seen in New York City at the Bellevue NYU Program for Survivors of Torture (PSOT)

***Correspondence**
Hawthorne E. Smith,
Bellevue/NYU Program for Survivors of Torture.
E-mail: Hawthorne.Smith@nyumc.org

BACKGROUND

Recurrent – Reinforcing Stressors

Many asylum seekers and traumatized refugees have undergone an ongoing series of complicated life events. They have survived social dislocation in their country of origin (including rebel insurgencies, civil war, ethnic cleansing, homophobia, religious strife or race-based slavery), perhaps capture and incarceration with direct experiences of torture; living as an internally displaced person in their homeland; escaping to a neighboring country under harrowing conditions; perhaps living in a refugee camp; and perhaps being detained upon their arrival in the United States. After arrival in the United States (Smith, Keller & Lhewa, 2007), most are considered undocumented immigrants, and therefore are not eligible for social services and medical care, and cannot work legally and support themselves and their families (Wilkinson, 2007). Although many may have been well-trained professionals with advanced educations in their countries of origin, they often work in positions below this level of expertise in menial, "off the books," jobs - if they are able to work at all. Research shows that refugees and asylum seekers who have not been able to find gainful employment in their host countries, or who have fewer social contacts, manifest increased levels of psychosocial distress; and that this continues many years after their initial victimization (Carlsson, Olsen, Mortensen, & Kastrup, 2006; Quiroga & Jaranson, 2005). In fact, recent data show that the emotional distress can be chronic for the majority of this marginalized population (Carlsson, Mortensen, & Kastrup, 2005).

Many of our clients, who were formerly of significant social stature in their home countries, are now confronted with a country, culture, and language that are entirely unfamiliar to them. They suddenly find themselves to be functionally illiterate, and must struggle for their very survival in their new socio-cultural setting. They may also harbor the fear that they will be "exposed" because of their tenuous immigration status, and deported back into the hands of those who would persecute them. These stressors vary based on one's immigration status. Understanding the officially designated differences between being a refugee, an asylum seeker, an asylee, or an undocumented immigrant has a profound impact on an immigrant's emotional functioning and day-today living circumstances (Wilkinson, 2007). Issues of safety and adaptation to life in this country are also stressful. Forced migrants may live in poor neighborhoods, occasionally in areas with high levels of crime and racial tension, in which many become victims of this crime. They may have to frequently change dwellings and some become homeless.

Such are some of the multi-faceted emotional stressors that feed into the disempowerment and psychological distress that torture survivors and those who are living in exile are grappling with on a daily basis. These multiple losses, the social dislocation, the feelings of fear and inadequacy, as well as the cultural/linguistic barriers are all part of the psychological reality for those living in exile as refugees . Akukwe, Smith & Wokocha, 2000; Randall & Lutz, 1991). Clinicians may conceptualize these recurrent stressors as "sequential traumatizations" (Basoglu et al., 1994; Quiroga & Jaranson, 2005). In our client population, these realities are superimposed on the detrimental physical and psychological effects of the torture experience itself.

We generally organize the negative effects of torture along domains of functioning, as opposed to a purely diagnostic framework. However, we also see the value in DSM-IV-TR (APA, 2004) diagnoses, but we recognize the limits in utility determined by cultural differences, or the potential for people to be stigmatized or resistant to the idea of psychiatric diagnoses. As such, we often look at secondary effects of human rights abuses as being active in the following domains of functioning: physical, emotional, cognitive, and behavioral. These are described below under those sub-headings.

COMMON REACTIONS TO TORTURE AND REFUGEE TRAUMA

Physical Functioning

The physical symptoms of torture and refugee trauma are varied, and may manifest themselves differently from client to client. There may be identifiable scars or disfigurements that document the trauma endured (i.e. cigarette burns, scars, missing teeth, fractures, wounds, and/or amputations). There may also be decrements in physical functioning due to the abuse suffered that leave no scars, such as impaired vision or poor hearing from violent blows to the head. Insomnia, nightmares, and other sleep difficulties are among the most frequently reported symptoms by torture survivors (Quiroga & Jaranson, 2005). Frequently, there will be no outward signs of the physical trauma, as many torturers want to inflict the maximum amount of physical pain without leaving visible physical scars (Berliner et al., 2004; Keller, Eisenman, & Saul, 1998; Shrestha & Sharma, 1995).

Some of the most common physical symptoms may be linked to psychological distress. Many clients come from cultures where emotional/psychological distress is stigmatized or not readily discussed or acknowledged (Briere, 2001; Elsass, 1997).

Symptoms of distress may manifest as somatic, physical ailments (Briere, 2001; Chester & Holtan, 1992; Johnson, Hardt, & Kleinman, 1994). Clients may not be ready or able to discuss psychological issues, but easily describe the physical or somatised ailments they experience. As is common in patients with somatization disorder, clients may complain of frequent headaches, generalized fatigue, gastro-intestinal difficulties, or musculoskeletal pains (Keller, et al, 1998; Piwowarczyk, Moreno, & Grodin, 2000). As these symptoms are being attended to, some of the connections between the physical and emotional symptoms get addressed by the health professional, with a potential goal of engaging the client for mental health services (Carrillo, Green, & Betancourt, 1999; Pope, Garcia-Peltoniemi, 1991).

Cognitive Functioning

Cognitive symptoms stemming from traumatic experiences are another major area of concern. According to many refugee resettlement workers across the country (with whom we have conducted training seminars) some of the symptoms which they see most often among their traumatized clients are cognitive in nature. Cognitive symptoms that are frequently reported include difficulty concentrating, memory difficulties, excessive rumination, and active attempts not to think about anything reminiscent of their traumatic experiences. Clients have reported that they are no longer able to retain what they have just read or heard. Frequently, clients may be caught between conflicting extremes of avoidance and intrusion (Elsass, 1997; Haenel, 2001; Horowitz, 1976). They may be inundated by intrusive symptoms such as ruminations and nightmares, by which they cannot stop reliving their traumatic experiences. Simultaneously, they may avoid or deny their experience, and suffer emotional numbing.

The etiology of the decrements in functioning must be assessed. Blunt-trauma to the head, traumatic brain injury, and the associated neurological impairment may be the root cause of cognitive impairment, but also purely psychological causes must be considered (Keller et al, 2003).

Emotional Functioning

Emotional functioning is another important sphere affected by trauma. Research with war survivors has shown that emotional difficulties and psychiatric diagnoses persist even after three years have elapsed since the fighting (Mollica et al., 2001). Studies have also shown that Post-traumatic Stress Disorder may manifest itself in particular ways depending on the cultural underpinnings of the survivor, including among West and Central African survivors (Rasmussen, Smith, & Keller, 2007). Other research shows that the co-morbid diagnoses of Depression and Post-traumatic Stress Disorder (PTSD) tend to improve slowly with time among Indo-Chinese refugees. However, these symptoms are prone to recur over time when exacerbated by external stressors. (Kinzie et al., 1997). It has been noted that Major Depression and PTSD are the two most frequently utilized diagnoses for this population, and that while PTSD seems to garner the most attention, Major Depression may be the most prevalent psychological stressor (Mollica, 2004). Again, research data indicate that the emotional distress becomes chronic for a majority of torture survivors living in exile (Baker, 1992; Carlsson et al., 2005). Clients may manifest emotional symptoms typical of someone who is grieving. Clients commonly become tearful, and may express sadness. They may express longing for family members and friends who are missing or have been left behind. These feelings of sadness and grief may be accompanied by suicidal thoughts or more passive questioning of the purpose of life in general. Other vegetative symptoms of depression often accompany these e.g. loss of appetite and weight or decreased libido, poor concentration and memory difficulties, loss of drive and energy etc (Briere & Scott, 2006; Elsass, 1998).

Clients may also report being fearful, distrustful, paranoid or frankly psychotic (Shrestha & Sharma, 1995). They may feel that they are being pursued by people who would harm them. This may be a function of the perceived hostile nature of their new environment, or it may be bolstered by delusional thinking. We have had a handful of clients who were convinced that the security forces from their home countries were working in tandem with the New York Police Department to spy on them and abuse them. This sense of fear and mistrust may make it difficult for them to engage in a trusting relationship. An example of how emotional responses may differ from client to client is the presentation of affect. Some clients will present in a volatile, emotionally charged manner. For many, there may be a wide range of emotions expressed as they recount their trauma history. Some may view relating their trauma history as a cathartic experience. In contrast, others may present with a flat affect. They may relate the most intimate and painful details of their trauma without changing the tone of their voice, or their rate of speech. The cognitive and emotional aspects of the personality may appear disconnected from one another (Randall & Lutz, 1991).

Behavioral Functioning

Changes in one's perceived health status, patterns of thinking, and emotional functioning will of course have significant impact on one's behavior. Behavioral functioning is another area where resettlement workers, teachers, and job counselors often report that they observe signs that comprehensive mental health services may be needed for a particular survivor. There may be signs of behavioral withdrawal that mirror the attempts to avoid thoughts that pertain to the traumatic past (Randall & Lutz, 1991). Some clients may avoid individuals who come from their home countries or their region of the world. Some clients report avoiding any information such as news broadcasts, internet reports, etc. about the situations in their home countries. Some have said that any new information, particularly negative news, can be overwhelming. In contrast, other clients may be very active in gathering as much information as possible. Clients have described this as an attempt to "stay connected to the struggle and people" they have left behind.

These dichotomous reactions reflect the precarious emotional balance that survivors are trying to maintain, and demonstrates the different ways that survivors may react to similar stressors. Clients may have difficulty balancing their needs for assurance and connection, while maintaining vigilance against external threats and triggers that may activate painful memories (Elsass, 1997; Haenel, 2001; Silove et al., 1991). They may fluctuate from behaving as though they are anesthetized, to experiencing intense surges of affect brought about by intrusive thoughts and dreams. Consequently, clients may manifest swift changes in mood. Many report becoming irritated without being cognizant of why their mood changed so quickly (Shrestha & Sharma, 1995). The difficulties with concentration and memory may display themselves as missed appointments, tardiness, and forgetting some of the specifics about the trauma history (Briere, 2001). This poses problems for the resettlement process, and may cause difficulties in seeking political asylum.

The emotional burden with which clients are coping may also manifest itself in an exaggerated startle response to noises. Sudden noises, particularly those that are similar to sounds that may have been heard during the traumatic period (i.e. a car back-firing may seem like gun shots), can cause the clients to become jumpy or perspire profusely. Clients may become visibly frightened and avoid people they encounter who are wearing uniforms, particularly if they have been tortured by people in official capacities such as police or military personnel. Clients may also seek coping mechanisms that are not always positive or therapeutic. This may lead to detrimental changes in behavior such as clients engaging in substance abuse. Such "self-medicating" behavior is common for people who suffer from anxiety disorders, including PTSD, and/or major depression (Briere & Scott, 2006). The literature shows that substance abuse levels among trauma survivors who develop full-blown PTSD are elevated, relative to levels among survivors who do not develop PTSD (Chilcoat & Breslau, 1998). Although reported substance abuse levels are higher among US war veterans than among traumatized refugees (i.e. Quiroga & Jaranson, 2005), it remains an area of significant concern, especially among younger male refugees, as the prevalence seems to be higher among men than women (Kastrup & Arcel, 2004). This is a potentially major issue to explore regarding survivors of refugee trauma who are searching for ways to cope with feelings of anxiety, hopelessness, and depression.

TREATMENT TECHNIQUES AND PRIORITIES

Given the multiple and recurrent stressors a survivor is facing, as well as the complex psychological reactions related to their experiences, some insights in terms of engaging this population in treatment are warranted. The following themes have proven to be important in our work at the Bellevue/NYU Program for Survivors of Torture (PSOT)(Smith, 2007a).

Emotional Safety

One of the factors that has become evident in our work with torture survivors is that fostering a sense of emotional safety is of paramount importance. This finding is echoed throughout the psychological literature, where developing a relationship of confidence and trust with torture survivors has been described as being the first priority in treatment (Briere & Scott, 2006; Fabri, 2001; Fischman & Ross, 1990; Haenel, 2001; Herman, 1992; Keller et al., 1998; Pope & Garcia-Peltoniemi, 1991; Silove, Tarn, Bowles & Reid, 1991; Somnier & Genefke, 1986; van der Veer & van Waning, 2004; Vesti & Kastrup, 1991).

This is particularly important for torture survivors. Some of the clients we treat at PSOT have been tortured by individuals in uniform in institutional settings. Many arrive at our hospital for their first visit, see crowds of people (including armed policemen and hospital security agents), become overwhelmed, and turn right around and go home. It is important to try to diminish the "negative institutional transference" that may exist for the client, so that they will be able to engage in treatment (Fischman & Ross, 1990; Smith, 2003) as illustrated in the story below.

XY, a 35 year old woman from Guinea, had a long history of abuse at the hands of Guinean police and para-military personnel due to her husband's involvement in an opposition political movement. The majority of her physical and sexual abuse was carried out by men in official uniforms, in civic settings, such as a police station or military barracks.

When XY first arrived at Bellevue for treatment, she was very frightened by the New York City police, hospital police, and other law enforcement personnel in uniform at the hospital. She returned home without keeping her appointment in our clinic. When she called to notify us why she was absent, we arranged to have the clinician meet her in the courtyard outside of the hospital. The clinician then accompanied her inside, and showed her the way to our clinic. Even when walking in the hall with the clinician, XY would shudder every time she saw a uniformed officer, and would position herself so that the clinician was always between her and the passing officer(s).

When greeting new clients and showing them the way to our clinic, program staff try to normalize the potentially confusing and intimidating hospital environment. This is consistent with psychological literature that describes normalizing a client's initial fears and anxieties as an important facet of creating a less threatening environment in which to begin treatment (Haenel, 2001). It may even be useful for a clinician to reframe a client's "anxiety" as a protective mechanism that has helped them to withstand the emotional turbulence they have experienced, and continue to experience (Gurris, 2001).

At PSOT, clients are often accompanied as they register and navigate the hospital bureaucracy, with program staff serving as interpreters and facilitators. Through this process the client may sense that they have an ally, and a trusting relationship may begin to germinate as the staff helps to make the initial contacts more humane and manageable. Seemingly small actions can have more impact than words, especially at the outset of treatment (Fabri, 2001; Silove et al., 1991). It is also important to remember that many survivors have been tortured in conjunction with being interrogated for information by people in powerful positions. This is of crucial therapeutic importance, particularly during the initial interview, as there is a significant danger of re-traumatizing the client if the therapist strictly adheres to their usual information gathering techniques. It is counterproductive to insist on "uncovering the whole story" if the client is emotionally unprepared to do so (Gangsei, 2001; Silove et al., 1991). The psychological literature states that it is preferable to strike a balance between uncovering the story and validating the client's experiences (Elsass, 1997; Haenel, 2001). The role of the therapist at this stage has been described as both, "witness and supportive human being" (Gurris, 2001 p. 51).

Clients may be reticent about sharing their stories for several reasons. They may fear that they won't be believed, or may be so ashamed of their experiences that they are reluctant to reveal them. They may vacillate between the intrusive and avoidant responses that accompany posttraumatic stress disorder, or perhaps they have not yet reclaimed the ability to fully trust another human being (Chester & Holtan, 1992; Elsass, 1997; Gurris, 2001). In fact, a client's "resistance" may be an adaptive coping mechanism learned while navigating hostile environments (Elsass, 1997). For all of these reasons, it is imperative that the clinician not engage in an "interrogation" of the client. The need for the client to feel safe outweighs the therapist's need to complete the necessary forms and paper work during the initial intake. Developing feelings of trust and safety comes first, and precedes any potential healing or resolution of traumatic symptoms through guided emotional expression (Haenel, 2001; Pope & Garcia-Peltoniemi, 1991).

During the first meeting, it may be helpful to engage the client in "anticipatory guidance," by which the clinician explains some common and expected symptoms that someone in the client's situation may experience. The therapist may also describe pertinent aspects of the recovery process, and the resources that their particular program can offer the client (Fischman, 1998; Smith, 2003). This helps to diminish some of the ambiguity that is frequently associated with incidents of psychological torture. During this phase, the client should also be enlisted as an active participant in prioritizing their needs and desires. Important questions should be addressed explicitly during this phase, like: Why should the client confide in you? What benefit is there in seeking the services you provide? What is the process like? How long might it take? What are the expectations of the client?

At PSOT, clients are encouraged to help decide how therapeutic resources will be prioritized and utilized. Efforts are made to understand a client's expectations of treatment, from a cultural perspective and in light of their traumatic experiences. We try to elicit the client's insights and desires regarding his or her treatment regimen. By this, we do not mean to say that a clinician should withhold his or her clinical point of view, or relinquish all control in terms of setting the direction of therapy.

Rather, we find that collaborating with the client in terms of clinical decision making helps them to engage in treatment initially. For psychotherapists, another unique aspect of forming an alliance with survivors of torture living in exile is that the usual therapeutic boundaries are often expanded. At PSOT, one way we have come to conceptualize our expanded role is as an "accompanier" (Fabri, 2001; Keller et al., 1998). This is one treatment approach utilized in our program that seems to help engage the client in a meaningful therapeutic relationship. Therapy does not simply consist of a 45-50 minute clinical hour, after which the client is not seen until the following week. As previously mentioned, therapists are sometimes enlisted to help the client navigate the hospital bureaucracy, facilitate referrals, and may function as translators and advocates for the clients within the hospital system.

EFFECTS OF PSYCHOLOGICAL TORTURE

Many specific techniques of psychological torture fall into large general categories. The good news is that there are ways that service providers can engage to lessen the torture effects for the survivors with whom they are working.

Ambiguity – The Unknown

Frequently survivors have no idea what is coming next. Placing people in a situation where they have no control and no power over what will happen next is often part of the torture experience. It is the aim of the perpetrators of torture that their victims (the survivors) are left to feel inadequate, powerless, and confused. Ambiguity and a general fear of the future are powerful tools used to assault one's psychological well-being. This is consistent with psychological literature in which survivors describe the anticipatory fear and pauses between torture sessions as the worst part of their mistreatment (Chester & Holtan, 1992; Gurris, 2001).

An example of this pattern is from a young torture survivor from Cote d'Ivoire who was repeatedly visited in his tiny, darkened prison cell by two different guards. The prisoner described one as the "good guard" and the other was the "evil guard." The "evil guard" would mistreat and physically abuse the prisoner, while the "good guard" would try to take a pleasant, non-threatening approach to interrogation (as in the "good cop, bad cop" scenario that is often portrayed in TV and movies). Every time one of the guards would leave, the prisoner was left literally "in the dark," not knowing who would appear next, or if his next "visit" would be the last of his life. During therapy, the survivor explained that "The time left alone in dark cell. Not knowing who would come next. Not knowing if anyone would come. Not knowing if the next person I saw would be my last. These moments were harder than physical torture."

The "Double Bind"

Survivors are placed in a position where no matter what decision they make – they are "wrong." They may come to feel responsible for their own suffering or the suffering of others. Victims are often forced to engage in incongruent actions, and are frequently placed in no-win, "double-bind" situations, where they are faced with impossible choices (Berliner et al., 2004; Shrestha & Sharma, 1995).

In one example of a "double-bind" situation, a member of a liberation movement in a West African country was imprisoned, interrogated, and physically tortured for many days. His captors were not able to elicit the information they desired, so they used a double-bind tactic.
A young, female member of the captive's family was captured and placed in the adjoining cell. The captive was given the choice of giving his captors the information they wanted, or witnessing the physical torture and rape of his young family member. No matter what choice this person made, it would be the "wrong choice" that would cause harm to his family member and/or his comrades in the liberation movement.

Survivor Guilt

Typically, this kind of situation leads to emotional conflict and uncertainty, a blurring of "right and wrong," and may assault the survivor's emotional integrity with a sense of self-blame and "survivor guilt." The survivor may feel as though they are unworthy of life or any sort of positive feelings, and may also feel that they have abandoned those who are still struggling and suffering in their home country. Survivors of torture are often led to believe that they are the ones guilty for inflicting pain on themselves and others (Elsass, 1997; Gurris, 2001; Somnier & Genefke, 1986). Clinicians can help to mitigate the effects of survivor guilt by practicing empathic listening skills, and by modeling that we can "tolerate" the difficult stories that our clients share with us. Often, the most powerful encouragement comes from those who have experienced similar challenges.

During a group session, a man from West Africa expressed great torment at the fact that he was living in the US while violence and uncertainty still racked his country. He questioned the value of his

own life. He was supported by a woman from a Central African country, who spoke of "Not giving the victory to those who have tormented you." Group members then discussed how they viewed their adaptation and striving to find pleasure to utilize resources, and to heal, as part of the ongoing struggle for human rights and justice. They spoke of "living" as opposed to "just surviving."

Utilizing other survivors, who refuse to allow their humanity to be destroyed, is an example of self-healing and empowerment. They become part of someone else's healing process. They can help others to internalize that "Living well is the best revenge," and as Bob Marley sang, "He who fights and runs away, lives to fight another day." Clients begin to see their own healing process as a manifestation of resistance and ongoing struggle

EMOTIONAL EMPOWERMENT

Empowerment in this context should not be confused with the notion of autonomy. While autonomy speaks to elevated functioning and independence, and is a goal generally reserved for later stages of trauma treatment (i.e. Herman, 1992), empowerment is focused more on communicating respect, and helping the client to internalize a positive sense of self-worth. Empowerment serves to facilitate "the innate tendency for humans to process trauma-related memories and to move toward more adaptive psychological functioning" (Briere & Scott, 2006, p. 67). For example, elevating the client in the therapeutic relationship, and offering an exchange between two individuals with unique resources and histories - not just an authoritative helper and helpless victim - helps the client to find their voice in the relationship. Clinicians can encourage the client's voice by taking a "collaborative" rather than an "expert" stance (Fabri, 2001; Smith, 2003). This may manifest itself in setting the pace for the initial interview or eliciting the the client's trauma narrative.

Therapists need to be flexible in their own conceptualization of the therapeutic relationship. We have already discussed how engaging the torture survivor in determining their own therapeutic priorities serves to empower them. This is particularly salient as "traditional" psychotherapy is an alien, and sometimes stigmatized, notion to many of our clients from non-Western societies (Akinsulure-Smith & Smith, 1997; Elsass, 1997). To insist that clients learn and internalize the cultural norms of "traditional" (otherwise known as "Western") psychotherapy places an additional cultural obstacle in front of them. Clients are already struggling to traverse cultural and linguistic barriers; giving them an additional hurdle, one more context in which they are unsure of the "proper" behaviors, serves to further disempower them. Being flexible and engaging clients in a more collaborative stance helps to give them an increased sense of personal control (Fabri, 2001; Gurris, 2001; Smith, 2003).

Another technique a clinician can use to balance the relationship is to allow clients to teach the therapist about their homeland, their culture, and other salient historical and/or social issues. Of course, it helps when the clinician has some knowledge about the country and situation from which the survivor has fled. This is a way of letting the client know that their past experiences exist on the therapist's cognitive "radar screen." However, a balance can be struck, where clients can broaden the therapist's contextual understanding of their history and culture. This is another therapeutic interaction that allows clients to feel that their knowledge, experiences, and insights are valued. This type of exchange also suggests to clients that they are respected as human beings with roots and who have something valuable to offer. This works to counter the belief among some survivors that they are powerless shells of their former selves, with nothing positive to share with anyone. As the client gains more confidence that they are being listened to and respected in the relationship, the resistance to engaging in the therapeutic process decreases (Akinsulure-Smith et al., 1997; Fabri, 2001).

Creating an environment in which the client feels emotionally safe and empowered, is a crucial element of forming a therapeutic alliance. However, there are other aspects of forming an alliance that may be unique to working with torture survivors who are living in exile. Below are some techniques, or therapeutic stances, that have proven to be effective across disciplines at the Bellevue/NYU Program for Survivors of Torture(PSOT).Our psychological work takes place within the context of a multidisciplinary treatment team. Psychologists work collaboratively with primary care physicians, psychiatrists, social workers, and activity therapists. Whenever possible, mental health and medical staff both meet with the client; especially when the client attends our specialized "Multidisciplinary Treatment Clinic," where they receive comprehensive evaluations and care from our clinicians. This is to give the client the sense that we work as a coordinated team, and to decrease the number of times a client may feel compelled to describe the details of the torture. This also models that our program provides diverse resources in terms of health and mental health care.

Describing psychological therapy as part of a "resource" model may help to alleviate some of the fear, misconceptions, or stigma regarding therapy that clients may harbor (Keller et al., 1998). Portraying ourselves as resources for the client also helps to empower the client in the relationship. Generally, this clinician tries to avoid asking a client the question, "How may I help you?" This simple question may be understood in the dichotomous context of the "all- powerful helper" and "helpless victim," which would be disempowering. Rather, it is recommended to try to express queries so that the client feels that they have choices and control. "What are your most pressing goals right now?" or "What services would be useful to you right now?" seem to be a more effective ways of framing the initial question. As such, we should draw on a survivor's strengths, and emphasize their resilience. For those of us working with survivors in exile, even expressly recognizing the fact that they speak several languages can help them to internalize the fact that we see them as intelligent capable people, even if they are struggling with the language of the host country (especially here in the United States where we barely speak one language well and always use slang).

These treatment priorities and techniques have been supported by the positive reactions of the clients in our treatment programs. The therapeutic relationships that develop are usually complex and profound. By empowering our clients, and listening to their insights, we have been able to develop therapeutic interventions that are increasingly culturally syntonic and effective for our client population. We feel that these overarching priorities are applicable to the variety of approaches to individual psychotherapy with survivors of torture and refugee trauma.

Combating Marginalization

In addition to the challenges one faces due to their traumatic histories, there are the ongoing issues of being displaced and marginalized on many different levels. As such, many of our therapeutic interventions are geared toward reducing the sense of marginalization. We combat marginalization in the emotional realm by normalizing one's perceptions of, and reactions to, the challenging scenario of forced adaptation. We frequently explore the dynamic of "characters. circumstances," and look at how many of the negative changes or challenges in a survivor's life are linked to circumstances, not general flaws in the person's character. This is especially important when a survivor Is experiencing disempowerment on many different levels (social, educational, professional, linguistic, etc.). We emphasize the temporal aspect of adjustment, and help to set realistic but hopeful goals. Our clients have become fond of saying "Nothing is easy, but everything is possible."

We have also learned from other programs like those represented here, as well as through our own experience, that efforts can be made to combat marginalization in the programmatic context as well. Efforts to foster a sense of programmatic belonging, whether through programs and community activities, as well as physical activity, psycho-educational and social groups, have proven to be successful. We have remarked that having program nicknames, like the "Fugees" soccer team in Georgia (St. John, 2009) or program t-shirts and caps that do not share identifying information that would breach confidentiality or safety have been effective. Activities that cross barriers to mainstream community have also been proven to be important in linking survivors to the program and the larger community (Akinsulure-Smith & Jones, 2011). Other "neutral" activities, like sports teams; gardening; parenting groups; spiritual/cultural gatherings; workshops geared to particular areas of challenge, have been successful. It is even more powerful when clients are engaged in the development of these activities.

Combating marginalization in the advocacy realm is also important for many reasons. By giving "a voice to the voiceless," we help to facilitate tangible improvements in the troubled waters which survivors are attempting to navigate. We can have a tangible impact on the needs of our clientele. When the survivors are enlisted to contribute to, and help guide, this effort, it helps to empower them, to engage them programmatically, and reduces survivor guilt, isolation, and inertia. They can see that they possess many ways to contribute to the ongoing struggle at home, even if they are geographically distant from their homeland. Survivors can begin to internalize the notion that they are "Not just needy - but are needed."

MULTICULTURAL ISSUES IN SERVICE PROVISION

Our client population at PSOT is extraordinarily diverse. Our African clients represent a continent that is comprised of 54 countries includung our brothers and sisters from the Republic of South Sudan, the world's newest independent nation, and a myriad of ethnicities. Just as our presenters also come from Chile, India, the UK, and the US, in addition to attendees from East, Central, South and West Africa , our client base is drawn from all over the world. We appreciate the diversity of the populations we serve. However, the focus here is on the aspect of multicultural inquiry. It is "The Power to Define" (Smith, 2007b).

The power to define one's self in terms of cultural

identity is an essential aspect of multicultural treatment. It can be an important tool for clients to define themselves in other areas of psychological functioning, such as educational goals and behaviors, substance abuse, career choices, etc. Self-definition may also pertain to perceptions of the conflict that the survivor has fled. Members of the host culture may misunderstand, or over-simplify the context in which torture took place and label these conflicts as "tribal warfare" or a manifestation of "age-old hatreds," as opposed to the complex socio-political circumstances that produce such violence (Berkeley, 2001; Weine & Laub, 1995). In contrast, it's generally the survivor who has a much more informed and nuanced understanding of the realities of the conflict situations from which they've fled. Empowering the client to express their contextual/political understanding can also help them to better comprehend the events that have impacted upon their lives, and the role that healing may play in the larger continuum as they endeavor to construct a future for themselves.

As such, aiding the client to develop understanding of their own reference group identities, within the context of the external messages that society sends, can help to empower the client to actively engage in the process of self-definition. When a client actively participates in the construction of meaning regarding their cultural identities, it can help them to navigate society more effectively (Elsass, 1997). The active construction of meaning can be a powerful tool for a traumatized refugee who is struggling to find their way in a new society, while preserving and treasuring their own cultural identity (Gurris, 2001).

An example of this pattern was an African adolescent client who was adjusting to life and school here in New York City. This young person was receiving a lot of pressure from local gang members to join the "Bloods" and engage in criminal behavior. In addition to threats, this client was frequently told that he was "selling out," not "keeping it real," or trying to "act like a White boy."

In session, we spent a lot of time exploring the client's views on what "Blackness" meant, and how life was different in his homeland. We talked about the history of the African Diaspora (the dispersal of African people through slavery and other population movements), and the wide variety of cultural and historical roles that Black people have played. After a few sessions, the client mentioned that he'd heard that there were probably a billion Black people in the world. He stated that, "If there are a billion Black people in the world, there must be a billion ways to be Black." The client began to internalize the power to define for himself what "Blackness" meant, and was eventually able to successfully resist the external pressures that were being placed upon him
(Smith, 2007b).

As displaced peoples try to make sense of their situation, and struggle to keep a positive sense of self, it may be a helpful intervention to explore upon what foundation a person bases their self-opinion. Our clients have spoken eloquently about making a distinction between personal character and personal circumstances. Acknowledgement that one's current situation need not define one's value as a human being can be empowering for refugees who are enduring educational and professional devaluation. Considerations of what refugees have endured and overcome may help to deepen their insights about their current situation, and help them to persist in pursuing their dreams and life aspirations. This can help a refugee to defend against externally defined negative evaluations of themselves. Our refugee clients are also helped to understand and navigate situations when their personal identity is contradicted by the identity that society places on them. Many of the cultural groupings and labels change from country to country. For example, they may find themselves defined by racial group in the US, when ethnic identities were more salient in their country. Most racial or cultural divisions are man-made and man-interpreted, as opposed to being true biological/chemical differences, so there may be significant variance from place to place.

For example I led an educational trip for American high school students to South Africa. When I got on the plane at J.F.K. in New York I was seen as a Black man. When I arrived in South Africa I was no longer considered Black; I was now "Coloured." Only people with 100% African blood, preferably belonging to one of the 11 indigenous groups in South Africa, are considered to be Black. This is directly opposed to the "one drop" conceptualization in the US, where any Black ancestry means that a person will be categorized as Black (Asante, 1990; Cater, 1995; Cross, 1994). Having my race "magically" change somewhere over the Atlantic during my flight helped me to appreciate the arbitrary nature of racial and cultural groupings. I realize, however, that these haphazard categorizations have real meaning in terms of understanding and navigating one's society (Smith, 2007b).

GROUP TREATMENT WITH "LA FAMILLE AFRICAINE" (GROUP PROCESS)

One of the treatment modalities we have found to be especially useful at PSOT has been supportive group treatment. Two of the primary goals that we identified for our treatment groups were that clients would feel supported, and that their sense of social isolation would decrease. In individual therapy, many African clients, for example, reported feeling "lonely," "all by themselves," or that "nobody could understand" their problems. Group treatment would strive to support these clients in multi-faceted ways consistent with the "curative factors" described by Yalom (1985) such as: hope, universality (the reduction of isolation), information sharing, altruism, and interpersonal learning. It was hoped that clients would come to find out that they were not alone, in terms of their torture experiences, or in terms of the challenges facing them as they attempted to adapt to life in the United States (Akinsulure-Smith, in press; Drozdek & Wilson, 2004; Smith, 2003).

Another major goal of the treatment groups (which include both an ongoing group for Francophone African torture survivors, and another for male, English speaking African survivors), which is consistent with the treatment priorities discussed earlier in this chapter, was to empower the client. The literature suggests that survivors, who are able to regain a sense of purpose in their lives, perhaps by building relationships and feeling useful in helping other people, have shown overall improvement in their psychological functioning (Akinsulure-Smith, in press; Berliner et al., 2004; Fischman, 1998; Fischman & Ross, 1990; Saxe et al., 1993; Smith & Impalli, 2007; Yalom, 1985). Our treatment groups were conceptualized with the hope that clients would begin to see that they are more than people who are needy. In an emotional sense, they would come to realize that they are people who are needed, as well. As clinicians, we also hoped to get a clearer understanding of the question, "What sort of resilience and coping mechanisms must a people utilize to survive such harsh life conditions?" In our long-term, ongoing groups, it was hoped that group members would be able to model for one another that progress was possible, and that progress has indeed been occurring. The social reinforcements would work in multiple directions, serving to create an environment where clients could begin to feel hopeful again.

In creating the support group for French-speaking African torture survivors, it was hoped that the group modality would be a more culturally syntonic way of addressing mental health concerns than individual psychotherapy. This idea was partially based on the Pan-African cultural norms of hospitality and openness, in which strangers, foreigners, and those who are not capable of supporting themselves are usually taken in and cared for by members of the community (Akinsulure-Smith, Smith, & Van Harte, 1997). Consequently, one of the major cultural difficulties that African immigrants report facing in America is the perceived individualism and hence lack of hospitality and communal support. Many African clients complain about "Western" society in terms of clichés such as, "It's every man for himself," "It's a dog-eat-dog world," and, of course, "Time is money" (Smith, 2003).

> *After spending an academic year studying in Africa, a young American man returned to the United States. During his stay in Africa he was struck by the openness and hospitality he experienced. Barely a day would go by when the American was not approached by a stranger that greeted him, asked about his background, or invited him to eat or drink tea. He felt a larger sense of "culture shock" upon his return to the US and its "individualistic culture," than when he first went abroad.*
>
> *Soon after his return to the US, the American walked in a park and noticed a man whom he believed to be from West Africa sitting on a bench. The gentleman's clothes were in a "Parisian mode" so the American spoke to him in French. The African gentleman responded with surprise and pleasure, and the two men struck up a conversation. All was well, until tears began to fall from the African man's eyes about five minutes into their conversation. When asked what was wrong, the African man responded, "I have been studying in your country for almost eleven months now. And you are the first person who has come to me to say 'hello.'"*
>
> *This dichotomy in how cultures respond to immigrants, visitors and "strangers" struck a nerve with the American, and made a profound impact on how he viewed the challenges of adaptation after immigration. These insights have helped to inform his clinical practice since then.*

We believe that for clients suffering from social isolation, and who are deprived of culturally appropriate coping mechanisms, that a supportive group in which collateral ties would be fostered would be a positive psychological intervention (Saxe et al., 1993). We consider the importance that is placed on the extended family in the Pan-African context. We strive to create an environment that might not seem as foreign as individual psychotherapy to our African clients, where a sense of family could be reformulated in a psychological sense. Our hypothesis is that African clients might be more likely to engage effectively in supportive therapeutic work in a context that seemed more aligned with the ways they might have dealt with significant stressors in their cultures of origin.

One of the daunting issues we face when beginning to institute group treatment at our program, is a relative lack of scientific literature regarding this subject with this population. We view this as being good news, as there is now so much room for

creativity, innovation and research (Smith, 2003). We hope that this is a conceptualization that will be shared widely. That not only is there a need for innovation, but the capacity exists as well. We recognize that the group model we have developed in a multi-national population of Africans living away from the continent may look a lot different from what one might appropriately put in place among a more homogeneous population that is still linked to the geographic area where violence and reprisals may continue to be realistic concerns. But we feel that certain aspects of our group experience still translate well. There is no predetermined content area for group discussions. As previously mentioned, group members may choose to share their previous trauma experiences, but the group focuses on many diverse areas. Sometimes the group focuses on concrete logistical issues, philosophical issues, social support, adaptation issues, and occasionally, issues regarding crisis intervention (Smith, 2003).

Group members frequently struggle with feelings of hopelessness, shame, and/or survivor guilt. These painful feelings are often brought up in-group, as members strive to cope with this tormenting emotional baggage. One way that group members have made sense of these feelings, and have supported each other, is to view these painful emotions as an intended part of the torture experience. It has been shown that being able to place the burden of responsibility on the perpetrators of torture for the current distress is an adaptive step on the way to recovery (Fischman & Ross, 1990; Smith, 2003; Somnier & Genefke, 1986). Some group members have stated that by giving into the feelings of guilt and hopelessness, they are giving power back to the torturers. They feel that fighting against these painful emotions and overcoming them, is like fighting against the torturers, and denying them their ultimate victory.

As an on-going open group, long-standing members will welcome new members and explain group processes, and share some of their experiences and benefits of the group. Although, much of this information is covered with the group therapist during the individual screenings for group therapy, it seems to carry much more weight when it comes from members who have lived through experiences similar to the newly arrived client's. This process helps to set a familial, collegial tone that helps a new member to feel like "they belong." In our long-term, on-going groups, it was hoped that group members would be able to model for one another that progress was possible, and that progress has indeed been occurring. The social reinforcements would work in multiple directions, serving to create an environment where clients could begin to feel hopeful again.

An example of how this multi-directional reinforcement manifested itself therapeutically was one occasion when a new client from a central African nation joined the group and attended his first session. The other attending members had been in the group anywhere from four to eighteen months. The new client presented as being depressed. At first, he would barely make eye contact and was hesitant to speak. On two occasions, he even put his head down on the table. Group members greeted him, and talked about what the group was like, and various ways they felt it had helped them.

The group members then began to catch up with one another and discuss various issues regarding adaptation to life in the US. The new client began to gain interest in the conversation, and started speaking up. He shared that he was often afraid to go out into his Harlem neighborhood. He admitted that he was supposed to have come to the group the previous week, but had gotten hopelessly lost on the subway. The other group members, who had been in the US for considerably longer than the new client, engaged him around his experiences.

They shared stories about when they first arrived in the United States. One client talked about taking the wrong train and ending up in Coney Island, and not knowing enough English to ask anyone how to get home. Another talked about being afraid to leave his Bedford-Stuyvesant apartment for his first six months in the country. He had seen many American movies with Stallone, Schwarzenegger, and the like; and when he saw kids on the street corners wearing big, bulky "South Pole" and "Bear" winter coats, he thought they were all "muscle men" like in the movies.

The group members told these stories about unpleasant, scary, or disempowering events, with unabashed humor and openness. Group members shared their vulnerability in an adaptive way, and everyone, including the new client, was laughing. It was the first time that he had ever seen to smile (Smith, 2003).

This interaction was powerful in three respects. By coming into contact with people who have encountered the difficulties he was currently facing, and seeing that they had learned to better navigate their environment, the new client was able to see that progress was possible.

Secondly, it was beneficial for the senior group members to be able to express and share painful incidents in a way that diminished their impact, by placing them firmly in the past - a past they could now laugh about. Thirdly, this interaction was empowering for senior members, many of whom were in the middle

of the asylum application process, which can drag on for months or even years. Some of these clients had previously expressed feeling stuck, like they were not making any progress. By meeting the new client, they saw a reflection of themselves a few months back. It helped clients realize that they had been making steady progress, even in the midst of feeling stuck.

In terms of concrete issues, group members often share insights, or vent frustrations regarding employment problems, immigration concerns, health issues, and social services in general. Group members have gone so far as to help find, or even provide, emergency shelter for members who have no place to stay. This would probably be frowned upon in more traditional group therapy. Group members help each other navigate the hospital system, so that members can access the medical care that they need, sometimes by acting as interpreters or showing new members where to find particular clinics or offices. Members help each other by providing guidance in terms of how they have navigated particular situations in the past, and they support each other when progress is slow, and frustration levels are high.

The philosophical group discussions are especially fascinating and rewarding. Group members share insights and proverbs from their homelands to help illuminate complicated issues. Group members have discussed the relative merits of "forgiveness" versus "forgetting" in terms of recovering from their trauma. They have explored the thin line between fear and wariness, and how it affects one's ability to navigate their new, and sometimes threatening, environment. Group members have also broached the subject of positive self-concept, and the importance of valuing one's personal character above and beyond one's troubling circumstances. They have also debated their perceptions of positive and negative aspects of their home cultures vis à vis the new culture they are attempting to navigate. Group members have discussed the frustrations of wanting to change the world, but feeling powerless to do so. They have discussed the need to look at change and progress gradually.

As previously mentioned, the group often focuses more on adaptation than emotional exploration. Adaptive defenses are supported, not dismantled. As always, special care is taken that group members are not re-traumatized by the therapeutic work. We have found it to be important to end sessions, particularly those that have been emotionally charged, in a way that leaves the clients feeling empowered and supported. It is helpful for the clinician to be able to sum up what has transpired in group in a way that focuses on the wisdom that was shared, the courage that was displayed, and most importantly, that engenders continued hope for the future. Our African group members have spoken about the importance of hope in their sessions.

> *In one session, the question was asked: What are the necessary qualities to change the world? Or at least survive the world? Amazingly, group members came to a consensus on such a broad and profound question. They identified three things: "Wisdom, courage and hope." And they explained that having any two of these three qualities - no matter which two - is insufficient.*
>
> *For, one who has the courage to make a change and the hope that it can work, but who lacks wisdom cannot manage their efforts effectively, and is doomed to fail. Conversely, a wise and hopeful person who lacks courage is forever locked in a state of inertia and inactivity. But the inherent wisdom of our African clients is clear. Need we even speak of the courage it takes to survive what they have experienced and still have the strength to take a chance on a new life in a new land that is different in so many ways?*
>
> *They shared that hope is what is difficult for them to hold on to. They described the importance of hope - with all of its potency and fragility. But they went even further and explained that: Hope is not so much something you have. It is something you do. There is an internal, proactive, self-generated capacity to hope. Perhaps even more importantly, the capacity to hope is something you share. "L'esprit de partage."*

CONCLUSION

In this paper, we have seen the myriad of ways in which empowerment can facilitate and enhance displaced African and torture survivors' ability to engage in treatment and create a new future for themselves. Whether it be about setting the context in which the survivors will feel capable and justified in accessing services; or finding ways to help them understand their emotional reactions as common (and understandably human) reactions to abnormal circumstances; or helping them to see their own healing process as part of their ongoing struggle – and not a betrayal of it; or to help them engage as part of the healing process for other survivors. We have seen that empowerment plays a crucial role in how survivors will adapt to their challenging circumstances. By utilizing the inherent strengths of our survivors – their wisdom and their courage – one can truly see the power of the phrase "African solutions to African challenges."

REFERENCES

Akinsulure-Smith, A.M. (in press). Using group work to rebuild community ties among displaced African men. Journal for Specialists in Group Work. Akinsulure-Smith, A., & Smith, H. (1997, February). Africans in America: Cultural and Environmental Considerations for Psychotherapy. Symposium conducted at the 14th Annual Teachers College Winter Roundtable on Cross-Cultural Psychology and Education. Teachers College, Columbia University, New York City.

Akinsulure-Smith, A., Smith, H., & Van Harte, E. (1997): Psychotherapy with Africans in America. Symposium conducted at Perspectives on Black Psychology: Past, Present, and Future, Pace University, New York City.

Akukwe, C., Smith, H., & Wokocha, E. (2000): Enhancing the well-being of African refugees. In I. Berhane (Ed.), Proceedings from the conference "African Refugees and the US response: Twenty years of resettlement" (pp. 67-74). Arlington, VA: Ethiopian Community Development Council/ African Resource Network.

American Psychiatric Association. (2004). Diagnostic and statistical manual of mental disorders (4th ed. Text Revision). Washington DC: Author.

Asante, M. K. (1990). Kemet, Afrocentricity and knowledge. Trenton: Africa World Press, Inc.

Baker, R. (1992): Psychological consequences for tortured refugees seeking asylum and refugee status in Europe. In M. Basoglu (Ed.), Torture and Its consequences: Current treatment approaches (pp. 83-101). Cambridge, England: Cambridge University Press.

Basoglu, M., Paker, M., Paker, Ö., Özmen, E., & Sahin, D. (1994): Factors related to long-term traumatic stress responses in survivors of torture. Journal of the American Medical Association, 272, 357-63.

Berkeley, B. (2001): The graves are not yet full: Race, tribe, and power in the heart of Africa. New York: Basic Books.

Berliner, P., Mikkelson, E., Bovbjerg, A., & Wiking, M. (2004): Psychotherapy treatment of torture survivors. International Journal of Psychosocial Rehabilitation, 8, 85-96.

Bhui, K., Abdi, A., Abdi, M., Pereira, S., Dualeh, M., Robertson, D., et al. (2003): Traumatic events, migration, characteristics and psychiatric symptoms among Somali refugees. Social Psychiatry and Psychiatric Epidemiology, 38, 35-43.

Briere, J. (2001, July): Evaluation, measurement, and assessment approaches with severely traumatized populations. Presentation to the Clinical Leadership Conference of the National Consortium of Torture Treatment Centers, Minneapolis, MN.

Briere, J., & Scott, C. (2006): Principles of trauma therapy: A guide to symptoms, evaluation, and treatment. Thousand Oaks, London, New Delhi: Sage Publications.

Carlsson, J.M., Mortensen, E.L., & Kastrup, M. (2005): A follow-up study of mental health and health-related quality of life in tortured refugees in multidisciplinary treatment. Journal of Nervous and Mental Disease, 193 (10), 651-657.

Carlsson, J.M., Mortensen, E.L., & Kastrup, M. (2006): Predictors of mental health and quality of life in male tortured refugees. Nordic Journal of Psychiatry 60 (1), 51-57.

Carlsson, J.M., Olsen, D.R., Mortensen, E.L., & Kastrup, M. (2006): Mental health and health- related quality of life: A 10 year follow-up of tortured refugees. Journal of Nervous and Mental Disease, 194 (10), 725-731.

Carrillo, J., Green, A., & Betancourt, J. (1999): Cross-cultural primary care: A patient based approach. Annals of Internal Medicine, 130, 829-834.

Carter, R.T. (1995): The influence of race and racial identity in psychotherapy: Toward a racially inclusive model. New York: John Wiley & Sons, Inc.

Chester, B., & Holtan, N. (1992): Working with refugee survivors of torture. Western Journal of Medicine, 157 (Special Issue: Cross-Cultural Medicine: A Decade Later), 301-304.

Chilcoat, H., & Breslau, N. (1998): Investigation of causal pathways between PTSD and drug use disorders. Addictive Behaviors, 23, 827-840.

Cross, W.E. (1994): Nigrescence theory: Historical and explanatory notes. Journal of Vocational Behavior, 44, 119-123.

den Velde, W.O., Hovens, J.E., Bramsen, I., McFarlane, A.C., Aarts, P.G.H., Falger, P.R.J., et al. (2000): A cross-national study of posttraumatic stress disorder in Dutch Australian immigrants. Australia New Zealand Journal of Psychiatry, 39, 919-928.

Drozdek, B., & Wilson, J. (2004): Uncovering: Trauma-focused treatment techniques with asylum seekers. In J.P. Wilson & B. Drozdek (Eds.), Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims (pp.243-276). New York: Brunner-Routledge.

Elsass, P. (1997): Treating victims of torture and violence: Theoretical, cross-cultural, and clinical implications. New York and London: New York University Press.

Elsass, P. (1998): The existence of a torture syndrome. Torture, 8, 58-64.

Fabri, M.R. (2001): Reconstructing safety: Adjustments to the therapeutic frame in the treatment of survivors of political torture. Professional Psychology: Research and Practice, 32(5), 452-

457.

Fischman, Y. (1998): Metaclinical issues in the treatment of psychopolitical trauma. American Journal of Orthopsychiatry, 68(1), 27-38.

Fischman, Y., & Ross, J. (1990): Group treatment of exiled survivors of torture. American Journal of Orthopsychiatry, 60 (1), 135-142.

Gangsei, D. (October 13, 2001): Developing a Narrative in the Psychological Assessment of Torture and Refugee Trauma. Paper presented at the Clinical Symposium of the Torture Treatment Center Consortium. Chicago, IL.

Gurris, N. (2001): Psychic trauma through torture – Healing through psychotherapy? In S. Graesner & N. Gurris (Eds.), Standing at the Side of Torture Survivors: Treating a terrible assault on human dignity (pp. 29-56). Baltimore, MD: Johns Hopkins University Press.

Haenel, F. (2001): Foreign bodies in the soul. In S. Graesner & N. Gurris (Eds.), Standing at the Side of Torture Survivors: Treating a terrible assault on human dignity (pp.1-28). Baltimore, MD: Johns Hopkins University Press.

Herman, J.L. (1992): Trauma and recovery: The aftermath of violence – From domestic abuse to political terror. New York: Basic Books.

Horowitz, M.J. (1976): Stress response syndromes. New York: Jason Aronsen.

Jaranson, J.M., Butcher, J., Halcon, L., Johnson, D.R., Robertson, C., Savik, K., et al. (2004): Somali and Oromo refugees: Correlate of torture and trauma history. American Journal of Public Health, 94, 591-598.

Jaranson, J.M., & Popkin, M. (Eds.). (1998): Caring for Victims of Torture. Washington, DC: American Psychiatric Press.

Johnson, T., Hardt, E., & Kleinman, A. (1994): Cultural factors in the medical interview. In M. Lipkin, S.M. Putnam, & A. Lazare. (Eds.), The Medical Interview (pp.153-162). New York: Springer-Verlag New York, Inc.

Kastrup, M.C., & Arcel, L. (2004): Gender specific treatment. In J.P. Wilson & B. Drozdek (Eds.), Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims (pp.547-571). New York: Brunner-Routledge Press.

Keller, A., Rosenfeld, B., Trinh-Shevrin, C., Meserve, C., Sachs, E., Leviss, J., Singer, E., Smith, H., Wilkinson, J., Kim, G., Allden, K., & Ford, D. (2003). The mental health of asylum seekers. The Lancet, 362, 1721-1723.

Keller, A., Eisenman, D. & Saul, J. (1998): Caring for survivors of torture in an urban, municipal hospital. Journal of Ambulatory Care Management, 21(2), 20-29.

Kinzie, J.D., Leung, P.K., & Boehnlein, J.K. (1997): Treatment of depressive disorders in refugees. In E. Lee (Ed.), Working with Asian Americans: A guide for clinicians (pp. 265-274). New York: The Guilford Press.

Lie, B. (2002): A 3-year follow up study of psychosocial functioning and general symptoms in settled refugees. Acta Psychiatrica Scandinavica, 106, 415-425.

Mollica, R.F. (2004): Surviving torture. New England Journal of Medicine, 351, 5-7.

Mollica, R., Sarajlic, N., Chernoff, M., Lavelle, J., Vukovic, I. & Massagli, M. (2001). Longitudinal study of psychiatric symptoms, disability, mortality, and emigration among Bosnian refugees. Journal of the American Medical Association, 286 (5), 546-554.

Piwowarczyk, L., Moreno, A., & Grodin, M. (2000): Health care of torture survivors. JAMA, 284, 539-541.

Pope, K., & Garcia-Peltoniemi, R. (1991): Responding to victims of torture: Clinical issues, professional responsibilities, and useful resources. Professional Psychology: Research and Practice, 22(4), 269-276.

Quiroga, J., & Jaranson, J.M. (2005): Politically-motivated torture and its survivors: A desk study review of the literature. Torture, 15 (Thematic Issue, 2-3), 1-111.

Randall, G., & Lutz, E. (1991): Serving survivors of torture. Washington, DC: Association for the Advancement of Science.

Rasmussen, A., Smith, H., & Keller, A. (2007): Factor Structure of PTSD symptoms among West and Central African refugees. Journal of Traumatic Stress, 20(3), 271-280.

Roth, G., & Ekblad, S. (2002): Decreased levels of cortisol and testosterone among mass evacuated adults from Kosovo with trauma experience and PTSD. European Psychiatry, 17 (Suppl. 1), 94s.

Saxe, B., Johnson, S., Barrett, P., Erickson-Fraser, L., Kalil, K., & Collins, N. (1993): From victim to survivor: A group treatment model for women survivors of incest. Ottawa, Ontario: National Clearing House on Family violence.

Shrestha, N., & Sharma, B. (1995): Torture and torture victims: A manual for medical professionals. Kathmandu, Nepal: Center for Victims of Torture, Nepal.

Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z. (1997): Anxiety, depression and PTSD in asylum seekers: Associations with pre-migration trauma and post-migration stressors. British Journal of Psychiatry, 170, 352-357.

Silove, D., Tarn, R., Bowles, R., & Reid, J. (1991): Psychosocial needs of torture survivors. Australian and New Zealand Journal of Psychiatry, 25, 481-490.

Smith H. (2007 a): Treatment techniques and priorities: A psychological approach to the patient. In
H Smith, A Keller, D. Lhewa (Eds.) Like a Refugee Camp on First Avenue: Insights and Experiences form the Bellevue/NYU Program for Survivors of Torture, 126-166. New York: Jacob and Valeria Langeloth Foundation.

Smith, H. (2007 b): Multicultural issues in the treatment of survivors of torture and refugee trauma: toward an interactive model. In H. Smith, A. Keller & D. Lhewa (Eds.) Like a Refugee Camp on First Avenue: Insights and Experiences form the Bellevue/NYU Program for Survivors of Torture, pp.38-64. New York: Jacob and Valeria Langeloth Foundation.

Smith, H. (2003): Despair, resilience, and the meaning of family: Group therapy with French-speaking survivors of torture from Africa. In R. Carter & B. Wallace (Eds.), Understanding and dealing with violence: Multicultural Perspectives (pp. 291-319). Thousand Oaks, CA: Sage Press, Inc.

Smith H. & Impalli E. (2007): Supportive group treatment with survivors of torture and refugee
trauma. In H. Smith, A. Keller & D. Lhewa (Eds.) Like a Refugee Camp on First Avenue: Insights and Experiences form the Bellevue/NYU Program for Survivors of Torture, 336-374. New York: Jacob and Valeria Langeloth Foundation.

Smith, H & Keller, A. (2007): The context in which treatment takes place: The multi-faceted
stressors facing survivors of torture and refugee trauma. In H Smith, A Keller, D Lhewa (Eds.) Like a Refugee Camp on First Avenue: Insights and Experiences form the Bellevue/NYU Program for Survivors of Torture, pp.1- 37. New York: Jacob and Valeria Langeloth Foundation.

Smith H, Keller A, Lhewa D. (2007): (Editors). Like a Refugee Camp on First Avenue: Insights and
Experiences form the Bellevue/NYU Program for Survivors of Torture. New York: Jacob and Valeria Langeloth Foundation.

Somnier, F., Vesti, P., Kastrup, M., & Genefke, I.K. (1992): Psychological consequences of torture: Current knowledge and evidence. In M. Basoglu (Ed.), Torture and its consequences: Current treatment approaches (pp. 56-71). Cambridge: Cambridge University Press.

Somnier, F., & Genefke, I. (1986): Psychotherapy for victims of torture. British Journal of Psychiatry, 149, 323-329.

van der Veer, G., & van Waning, A. (2004): Creating a safe therapeutic sanctuary. In J.P. Wilson & B. Drozdek (Eds.), Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims (pp.187-219). New York: Brunner-Routledge.

Vesti, P., & Kastrup, M. (1991): Psychotherapy for torture survivors. In M. Basoglu (Ed.), Torture and its consequences: Current treatment approaches (pp. 349-362). Cambridge, UK: Cambridge University Press.

Weine, S., & Laub, D. (1995): Narrative constructions of historical realities in testimony with Bosnian survivors of "ethnic cleansing." Psychiatry, 58(8), 246-260.

Wilkinson, J. (2007): Immigration dynamics: Processes, challenges and benefits. In H. Smith, A. Keller, D. Lhewa (Eds.) Like a Refugee Camp on First Avenue: Insights and Experiences form the Bellevue/NYU Program for Survivors of Torture, 65-81. New York: Jacob and Valeria Langeloth Foundation 2007.

Yalom, I.D. (1985): The theory and practice of group psychotherapy. (2nd ed.). New York: Basic Books.

Yalom, I.D. (1995): The theory and practice of group psychotherapy. (3rd ed.). New York: Basic Books.

Using Mixed-Methods Research To Adapt And Evaluate A Family Strengthening Intervention In Rwanda

Theresa S. Betancourt[1]*; Sarah E. Meyers-Ohki[2]; Anne Stevenson[2]; Charles Ingabire[3]; Fredrick Kanyanganzi[3]; Morris Munyana[3]; Christina Mushashi[3]; Sharon Teta[3]; Ildephonse Fayida[3]; Felix Rwabukwisi Cyamatare[3]; Sara Stulac[3];William R. Beardslee[4]

1. Harvard School of Public Health, Department of Global Health and Population/François-Xavier Bagnoud Center for Health and Human Rights; 651 Huntington Avenue, FXB Building 7th Floor, Boston, MA 02115, USA
2. Harvard School of Public Health, François-Xavier Bagnoud Center for Health and Human Rights
3. Partners In Health, Rwanda/Inshuti Mu Buzima
4. Children's Hospital Boston

Abstract

Background: *Research in several international settings indicates that children and adolescents affected by HIV and other compounded adversities are at increased risk for a range of mental health problems including depression, anxiety, and social withdrawal. More intervention research is needed to develop valid measurement and intervention tools to address child mental health in such settings.*

Objective: *This article presents a collaborative mixed-methods approach to designing and evaluating a mental health intervention to assist families facing multiple adversities in Rwanda.*

Methods: *Qualitative methods were used to gain knowledge of culturally relevant mental health problems in children and adolescents, individual, family and community resources, and contextual dynamics among HIV-affected families. This data was used to guide the selection and adaptation of mental health measures to assess intervention outcomes which were subjected to a quantitative validation exercise. Qualitative data and community advisory board input also informed the selection and adaptation of a family-based preventive intervention to reduce the risk for mental health problems among children in families affected by HIV. Community-based participatory methods were applied to ensure that the intervention targets relevant problems manifest in Rwandan children and families and builds on local strengths.*

Results: *Qualitative data on culturally-appropriate practices for building resilience in vulnerable families has enriched the development of a Family-Strengthening Intervention (FSI). Input from community partners has also contributed to creating a feasible and culturally-relevant intervention. Mental health measures demonstrate strong performance in this population.*

Conclusion: *The mixed-methods model discussed above represents a refined, multi-phase protocol for incorporating qualitative data and community input in the development and evaluation of feasible, culturally-sound quantitative assessments and intervention models. The mixed-methods approach may be applied to research in other parts of sub-Saharan Africa and beyond.*

AJTS JUNE 2011 2(1): 32-45

Introduction

In Rwanda, as in much of Sub-Saharan Africa (SSA), major forms of adversity including armed conflict, widespread poverty, and the HIV/AIDS pandemic have increased threats to child survival and development, with significant consequences for child and adolescent mental health (1-6). Many older adolescents, for example, have experienced multiple and compounded forms of adversity, for instance exposure to communal violence and loss of a caregiver, putting them at even higher risk of developing problems like post-traumatic stress disorder (PTSD) and depression (7). In particular, being orphaned by HIV/AIDS and/or being forced to take on adult roles in order to help counteract caregiver impairment due to chronic illness are thought to have negative cascade effects on children's mental health and development (2, 8, 9). In these situations, young people may drop out of school to care for younger children or to help with family economic responsibilities. When family members are living with HIV, children may also have worries about their own health status, or may have misconceptions about how HIV is transmitted (3, 10-12).

In Rwanda, instances of compounded adversity are widespread. Although the prevalence of HIV has fallen in the past several years, many families continue to live with the illness in poverty and without strong access to services (13). The country's past history of genocide and war has been linked with widespread PTSD (14-17) and depression (18, 19)

***Correspondence:**
Theresa S. Betancourt
Harvard School of Public Health, Department of Global Health and Population/François-Xavier Bagnoud Center for Health and Human Rights; 651 Huntington Avenue, FXB Building 7th Floor, Boston, MA 02115, USA

in adults nationwide, problems which are thought to have important intergenerational effects

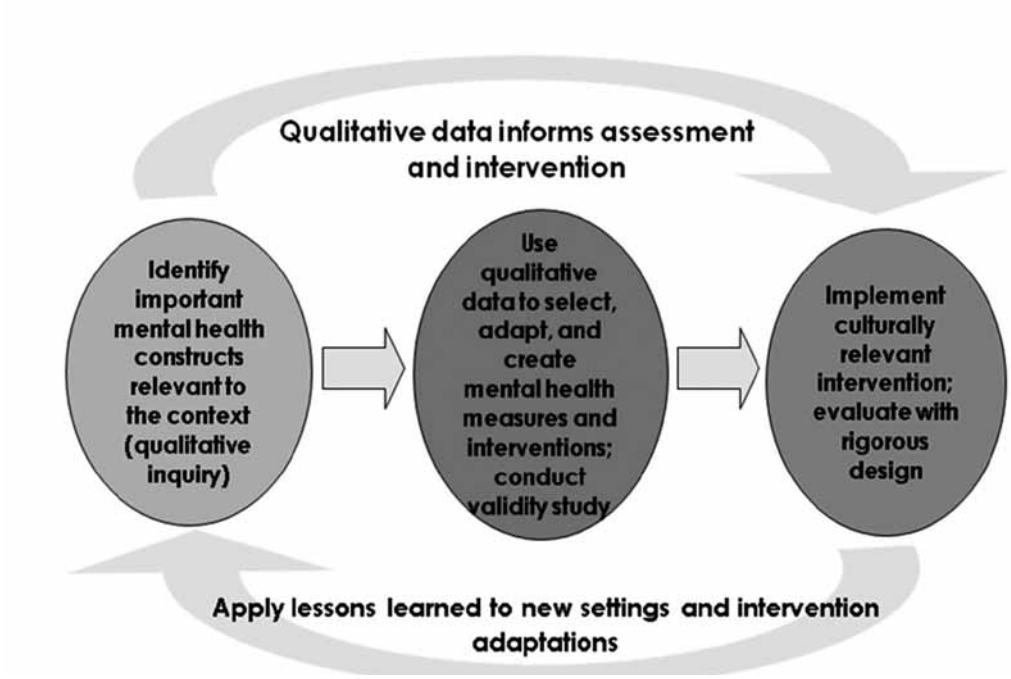


Figure 1. Application of Qualitative Data: Mixed Methods Cycle

on parenting and child development (20-27).

However, despite the high potential risk for mental health problems among children and youth facing adversity in Rwanda, current research concerning child mental health outcomes is limited. In fact, in low and middle-income countries overall, the vast majority of child mental health research focuses primarily on PTSD, general anxiety, and depression, with scant attention paid to other disorders, such as conduct problems, learning disorders and substance abuse (1). A dearth of evidence on culturally-sensitive screening scales and diagnostic procedures has made it difficult to identify and track children suffering from mental health problems (28, 29). To date, only a handful of studies have adapted and validated measures for use with children in SSA where standard mental health assessments based on Western diagnostic systems may fail to measure critical concepts relevant to the study population (28, 30-34). Without knowledge of local expressions of distress (which may be fundamentally different given local experiences, culture, and language), researchers cannot assume that simple forward and back translations of standard measures have cultural validity and generalizability (29, 33, 35, 36).

Given these measurement challenges, more culturally-informed research is needed to create and implement appropriate, interventions for addressing and preventing mental health problems in children affected by adversities such as war and HIV/AIDS (37). In this article, we use the example of an ongoing collaborative research project in Rwanda to demonstrate rigorous mixed-methods that can be used as a model for developing both culturally-informed assessments and intervention models. In the multi-step process used in this mental health services research, we aimed to (1) carefully unpack locally-relevant indicators of mental health problems and protective resources using qualitative methods; (2) apply qualitative findings to the adaptation of mental health measures and the development of a locally-informed intervention; (3) validate the selected mental health measures and (4) apply the measures to rigorous evaluation research on the effectiveness of the intervention chosen through the mixed methods process (see Figure1). This approach, applied by the first author and colleagues in several settings in sub-Saharan Africa (38, 39) is intended to explore how mental health problems and protective resources are expressed locally, and in its application of evidence to improved assessment and intervention development. Further, it is intended to increase sustainability and feasibility of the mental health services models developed through robust use of community feedback (40, 41). Methods and findings from recent application of the approach to research in Rwanda are briefly described below.

Methods

This research stems from a partnership launched in 2005 between the Rwandan government and the non-governmental organization, Partners In Health, Rwanda/Inshuti Mu Buzima (PIH/IMB), to strengthen the public health system in rural, underserved areas of the country. In 2007, the first author and the Harvard School of Public Health formed a collaboration with PIH/IMB and the Rwandan Ministry of Health and its Centre Psychosocial to improve the knowledge base on child and family mental health and functioning in Rwanda, as outlined in the framework presented in Figure 1.

Introduction

In Rwanda, as in much of Sub-Saharan Africa (SSA), major forms of adversity including armed conflict, widespread poverty, and the HIV/AIDS pandemic have increased threats to child survival and development, with significant consequences for child and adolescent mental health (1-6). Many older adolescents, for example, have experienced multiple and compounded forms of adversity, for instance exposure to communal violence and loss of a caregiver, putting them at even higher risk of developing problems like post-traumatic stress disorder (PTSD) and depression (7). In particular, being orphaned by HIV/AIDS and/or being forced to take on adult roles in order to help counteract caregiver impairment due to chronic illness are thought to have negative cascade effects on children's mental health and development (2, 8, 9). In these situations, young people may drop out of school to care for younger children or to help with family economic responsibilities. When family members are living with HIV, children may also have worries about their own health status, or may have misconceptions about how HIV is transmitted (3, 10-12).

In Rwanda, instances of compounded adversity are widespread. Although the prevalence of HIV has fallen in the past several years, many families continue to live with the illness in poverty and without strong access to services (13). The country's past history of genocide and war has been linked with widespread PTSD (14-17) and depression (18, 19) in adults nationwide, problems which are thought to have important intergenerational effects on parenting and child development (20-27).

However, despite the high potential risk for mental health problems among children and youth facing adversity in Rwanda, current research concerning child mental health outcomes is limited. In fact, in low and middle-income countries overall, the vast majority of child mental health research focuses primarily on PTSD, general anxiety, and depression, with scant attention paid to other disorders, such as conduct problems, learning disorders and substance abuse (1). A dearth of evidence on culturally-sensitive screening scales and diagnostic procedures has made it difficult to identify and track children suffering from mental health problems (28, 29). To date, only a handful of studies have adapted and validated measures for use with children in SSA where standard mental health assessments based on Western diagnostic systems may fail to measure critical concepts relevant to the study population (28, 30-34). Without knowledge of local expressions of distress (which may be fundamentally different given local experiences, culture, and language), researchers cannot assume that simple forward and back translations of standard measures have cultural validity and generalizability (29, 33, 35, 36).

Given these measurement challenges, more culturally-informed research is needed to create and implement appropriate, interventions for addressing and preventing mental health problems in children affected by adversities such as war and HIV/AIDS (37). In this article, we use the example of an ongoing collaborative research project in Rwanda to demonstrate rigorous mixed-methods that can be used as a model for developing both culturally-informed assessments and intervention models. In the multi-step process used in this mental health services research, we aimed to (1) carefully unpack locally-relevant indicators of mental health problems and protective resources using qualitative methods; (2) apply qualitative findings to the adaptation of mental health measures and the development of a locally-informed intervention; (3) validate the selected mental health measures and (4) apply the measures to rigorous evaluation research on the effectiveness of the intervention chosen through the mixed methods process (see Figure1). This approach, applied by the first author and colleagues in several settings in sub-Saharan Africa (38, 39) is intended to explore how mental health problems and protective resources are expressed locally, and in its application of evidence to improved assessment and intervention development. Further, it is intended to increase sustainability and feasibility of the mental health services models developed through robust use of community feedback (40, 41). Methods and findings from recent application of the approach to research in Rwanda are briefly described below.

Methods

This research stems from a partnership launched in 2005 between the Rwandan government and the non-governmental organization, Partners In Health, Rwanda/Inshuti Mu Buzima (PIH/IMB), to strengthen the public health system in rural, underserved areas of the country. In 2007, the first author and the Harvard School of Public Health formed a collaboration with PIH/IMB and the Rwandan Ministry of Health and its Centre Psychosocial to improve the knowledge base on child and family mental health and functioning in Rwanda, as outlined in the framework presented in Figure 1.

Step 1: Qualitative Studies

To explore local perceptions of mental health problems facing HIV-affected children in Rwanda, the study team interviewed children (aged 10-17 years) (N=71) and their caregivers (N=57) in Kinyarwanda using free listing and key informant methods. Questions were designed to elicit information on local mental health problems and the terminology used to describe them. In 2009, a second qualitative study was completed to identify the strengths and sources of resilience that individuals and families draw upon to overcome or prevent these problems. This 2009 study also used free listing exercises (N=21) and key informant interviews (N=68), as well as focus groups (N=9 groups). In both studies, participants represented a variety of community members and

professionals.

Participants in free listing exercises were drawn from hospital waiting areas at Rwinkwavu District Hospital. Focus groups were composed of HIV-affected family members and were separated by gender and by age (caregivers; children ages 10-13; children ages 14-17). Additional focus groups were held with community health workers, accompagnateurs, social workers, mental health staff, and pediatric doctors who interact regularly with HIV-affected families. Key informants were community members and health professionals identified as having particular knowledge about mental health syndromes in children and resilience in families; many, but not all, were HIV-affected. Key informants were nominated by PIH/IMB staff and by focus group participants; additional key informants were identified via snowball sampling whereby one participant nominated other potential participants.

Thematic Content Analysis (TCA) was employed to distill and classify important indicators of children affected by HIV/AIDS. The research identified several categories of locally-defined syndromes indicative of the mental health needs of children in this setting (42). *Guhangayika* (worry or stress manifest in mixed anxiety and depression-like symptoms) was explained as quite common among HIV-affected children and adolescents. When left untreated, *guhangayika* can develop into agahinda kenshi (persistent sorrow). *Kwiheba* (hopelessness and self-destructiveness) was described as an even more serious manifestation of depression-like problems in youth with a lead features including suicidal ideation and attempts. Problems such as *umushiha* (constant irritability/anger) and *uburara* (delinquent and high-risk behavior) were described as feeding a cycle of interpersonal difficulties, social withdrawal and isolation which could also lead to *kwiheba*. Some participants also discussed *ihahamuka*, a term describing the consequences of extreme trauma related to the genocide or the diagnosis of HIV (42).

Additionally, several local protective processes (i.e., strengths that help to prevent and mitigate the above problems) were identified (43). They included individual factors such as *kwihangana* (perseverance or patience) and *kwigirira ikizere* (self-esteem/self-confidence), which were thought to be fostered by family factors such as *kwizerana* (family connectedness) and uburere bwiza (good parenting), and by larger community factors such as *ubufasha abaturage batanga* (collective support) (43).

Step 2a: Apply Qualitative Data to Measurement Development/Validation

Once our findings were reviewed and approved by local partners and community advisory board members, the research team members performed an extensive search of the literature to identify standardized measures that could potentially evaluate each of the six mental health problems and five protective processes. Search criteria included prior cross-cultural application with children and prior use with good psychometric properties when adapted to low-resource, low-literacy settings. Identified scales were then evaluated for how well they assessed local indicators, as well as for their overall appropriateness to the Rwandan context. Any measure covering less than 50% of local indicators was dismissed from consideration. When no good match was observed, new measures were developed for individual constructs using the qualitative data. Specific items were created to correspond to each of the construct's indicators and were reviewed by a local psychologist.

Each selected measure was translated from "source language" (English) to "target language" (Kinyarwanda) according to a protocol informed by current literature: (a) two independent forward-translations were (b) combined to create a best forward-translation, which was (c) back-translated and (d) reviewed to resolve discrepancies, improve clarity, and ensure cultural relevance (44-49). Each of the measures was pre-tested in multiple rounds of cognitive testing with small samples of 3-5 children ages 10-17 years. Research Assistants (RAs) probed to understand how participants interpreted each question across the age range. A structured worksheet provided space for RAs to transcribe the responses verbatim. The study team reviewed responses and discussed items requiring revision. Modifications were implemented in order to maximize comprehensibility, and pre-testing continued until good comprehension across participants was indicated. The survey was then piloted among a small sample of children (n=9) and their caregivers (n=9) to attend to issues of fatigue or lack of clarity in any remaining items.

To evaluate test-retest reliability, children (n=36) and caregivers (n=36) completed a baseline assessment and follow-up assessment 1-3 days later. Two-thirds of participants completed a second interview with a different RA in order to provide data on inter-rater reliability. Test-retest and inter-rater reliability were assessed using Pearson's correlation coefficients; instrument internal reliability was assessed using Cronbach's alpha coefficients.

A full validity study to assess how well the assessments correctly identify cases of mental health disorders was then conducted. In this process, local community health workers generated lists of children (ages 10-17 years) thought to have at least one of the local mental health syndromes, as well as a list of children thought to have none of these syndromes. RAs blinded to the possible syndrome status of the child administered the entire survey to each participant. Children and caregivers also reported (via a simple

yes/no response) whether or not they thought the child participant had constructs the given mental health syndrome using local terminology. Then, in a separate
interview, a mental health clinician interviewed each child participant using the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-Kid) a structured diagnostic interview designed to evaluate DSM-IV disorders and their clinical judgment to determine the presence of any of the following mental disorders: Major Depressive Episode, Generalized Anxiety Disorder, Oppositional Defiant or Conduct Disorder and Post-Traumatic Stress Disorder. MINI-Kid modules for Suicidality and Psychosis were also administered in Kinyarwanda. This step allowed examination of the construct validity of measures, since many DSM-IV disorders map closely to the local mental health syndromes, although the local syndrome *umushiha* (a disorder of persistent irritability and anger) is only partially captured by Dysthymia. Patterns of agreement between the gold standard (MINI-Kid assessment), and the scores on the administered mental health measures and the child/caregiver self reports were evaluated using t-tests, kappa and receiver operating characteristic (ROC) analyses for sensitivity and specificity (38, 39). These analyses were used to determine local clinical thresholds for the mental health measures.

Step 2b: Apply Qualitative Data to Intervention Development

To select an appropriate intervention, we examined qualitative data on common expressions of mental health problems in children and adolescents and sources of strengths in children and families facing adversity, particularly those resources thought to promote good adjustment and prevent mental health problems (50). Qualitative data revealed that family communication, good parenting, family connectedness, and parental understanding related to illness was critical to promoting child wellbeing despite adversity, leading us to hypothesize that a family-based intervention focused on reinforcing strong parent-child relationships would be well-suited to the context of families affected by HIV in Rwanda and could be implemented as a preventive intervention as families came into contact with care systems (51). These hypotheses were shared and discussed with community advisors.

To support our inclination towards a family and strengths-based intervention, we examined the broad cross-cultural literature on family interactions and their impact on child development. Across a range of settings and cultures, findings underscore that positive family and larger community interactions are critical enabling factors for good child and adolescent mental health in the face of hardships (52-56). In particular, early risks for childhood mental health problems are often associated with early family adversity such as parental mental health problems, poverty, exposure to violence, chronic illness and social isolation (57-60).

Strengths-based preventive interventions focus not only on addressing these types of risk factors, but also seek to strengthen resilience and build on naturally-occurring cultural and family strengths in order to facilitate positive outcomes (61-63). A strengths based perspective has informed a large base of interventions in low, middle and high-income settings (64-66), including programs that focus on preventing mental health problems in children affected by HIV/AIDS (67, 68). In addition, many preventive programs look beyond the immediate family system and also aim to improve community relations and provide psychoeducation to larger populations in order to raise awareness and expand local networks of support (69). However, evaluations of such interventions in low-resource and non-Western populations are lacking. In particular, to our knowledge, no family-based prevention programs have been evaluated for use in Sub-Saharan Africa.

Despite the absence of existing strengths-based, family-based prevention programs for Sub-Saharan Africa, an examination of Western interventions revealed strong synergies between our primary protective processes of interest (family connectedness and communication, caregiving skills, and access to social support) and those leveraged by the Family-Based Preventive Intervention (FBPI) developed by Dr. William Beardslee of Children's Hospital Boston. The FBPI focuses on identifying and enhancing resilience in families and was one of the earliest programs to adopt a holistic, ecological approach to chronic family illness (70, 71). The intervention was also one of the first family-based mental health preventive interventions to demonstrate effectiveness in large-scale efficacy trials (72). It has demonstrated sustained effectiveness in low-resource and diverse cultural settings including among low income Latino mothers and among the Blackfeet Indian Nation (73, 74)

Trials of FBPI (also called "Family Talk") have found it to be acceptable, feasible, and related to long-term changes including greater child understanding of caregivers' symptoms, improved family functioning, increased recognition and treatment of subsequent symptoms, and decreased internalizing symptoms in youth (75, 76). This model has demonstrated sustainability via integration within existing public health service systems in Finland and Costa Rica (53, 77), and it is recognized by the National Registry of Effective Programs and Practices (NREPP).

We elected to use the FBPI as a foundational

model for our Family-Strengthening Intervention in Rwanda (FSI-R), and sought to adapt it using qualitative data and ongoing community feedback. Different national and international adaptations of the FBPI have produced standardized manuals and training materials, which we used as the basis for the FSI-R. Our collaborative process involving routine input from community advisory boards, clinical collaborators at Partners in Health and the Ministry of Health are intended to adapt the manuals and other intervention materials to the context of HIV in families and to the Rwandan culture. Collaboration with clinical experts such as Dr. Beardslee in the U.S. and local mental health professionals such as Ms. Mushashi, Mr. Inagbire and Ms. Teta as well as, community advisory boards were used to generate discussion and feedback loops about intervention materials. The adapted manual weaves together activities to build parenting skills, improve family communication, provide psychoeducation on HIV and trauma, and strengthen problem-solving skills, with the intent of strengthening families in six areas that can help prevent mental health problems in children:

1. First, it addresses misinformation and misconceptions about the illness in the family and community. Psychoeducation provides information about diagnosis and treatment of HIV infection, as well as ways of destigmatizing the illness.
2. Second, this family-based prevention program supports parents by encouraging strong *kurera neza* (parenting skills). It reminds parents that they can be good parents despite HIV/AIDS, and helps them to recognize the community supports, *ubufasha abaturage batanga*, that already exist around them.
3. Third, it addresses caregiver fears and concerns. In the context of HIV/AIDS, many caregivers and children work about what might happen to the child should the infected caregiver die or become very ill. Concerns about the child becoming infected are also common. The intervention helps families to talk about these fears, address misinformation and create plans for action. Additionally, the intervention works to educate foster caregivers taking care of children orphaned by AIDS.
4. Fourth, the intervention provides hope. An experience common to those living with HIV is a sense of hopelessness about the future, which can be made worse by experiences of stigma. The intervention helps families to tell their unique family story, identify sources of strength and resilience and build a more positive and future-oriented outlook. This process of building a family narrative from the caregiver perspective, the child perspective and the family perspective can help to build a sense of perseverance *(kwihangana)* and self-esteem *(kwigirira ikizere)* in children and improve family unity (*kwizerana*) and communication.
5. Fifth, the intervention recognizes that families are facing many different hardships. Therefore, in addition to giving information on HIV/AIDS, the intervention helps families to think about the social, medical, and community resources available to them. It uses family discussions to deepen family communication, trust and unity *(kwizerana)* so that they can start addressing these problems.
6. Sixth, the intervention takes a public health approach to care. This means that primary health care services at the hospital and eventually at the Ministry of Health are committed to find ways to integrate features of the intervention and other preventive services into their usual care.

Step 3: Implement and Evaluate Intervention

In future trials of the FSI, intervention impact will be assessed using the culturally-adapted and validated mental health battery developed in Step 2a. It will be tested among a small group of families (n=10), and then among a larger group (n=80). To assess if it is effective, participants will complete mental health measures before and after the program. The intervention will be delivered by our study's mental health clinicians, and supervised by research coordinators and the Project Manager. Should any problems arise during the course of this study, the Rwinkwavu Hospital mental health team available for referral and follow up.

Primary outcomes of interest include increases in locally-important protective processes and prevention of mental health problems (or maintenance of below clinical-threshold levels of symptoms and impairment). In addition to these quantitative measures, feedback surveys for FSI participants and interventionists will provide information on the program's cultural acceptability and feasibility and participant satisfaction. Evaluation of this data will inform protocol modifications to ensure broad public health relevance. In particular, information on sustainable methods for integrating the FSI into standard services is sought. This process completes the full mixed-methods cycle by providing iterative qualitative feedback to inform quantitative assessment and services implementation research.

Discussion

The mixed-methods model for planning and evaluating mental health services presented here addresses a number of issues inherent in cross-cultural research

with children and youth. It uses the community's self-identified needs to guide measurement and intervention development (78), and incorporates high levels of community participation, which increases the cultural-acceptability, feasibility and potential sustainability of interventions (79-81). Additionally, rigorously validated measures informed by qualitative data help to ensure that findings on intervention efficacy are accurate and locally-relevant.

In the specific case of Rwanda, qualitative findings on local strengths were particularly useful for guiding selection of an appropriate intervention. Previously, intervention research in Rwanda has largely focused on treating acute trauma exposures at the individual level (82, 83). Our qualitative investigation of mental health risk and protective factors, however, allowed for the organic identification of a locally- and contextually-appropriate intervention targets with relevance to children facing multiple adversities (84-86). In particular, findings on important local constructs such as family unity (*kwizerana*), good parenting (*uburere bwiza*), and social support (*ubufasha abaturage batanga*) provided evidence on modifiable protective resources that may be leveraged by interventions, a strategy used with great success in more developed countries to promote resilience despite risk (71, 87-89). An ecological-developmental model of stress-adjustment (Figure 2) provides a foundational framework for strengths-based interventions. This model blends the ecological-development framework (90) – which holds that risks and resources operate at different levels of the social ecology – with the stress-adjustment-paradigm (91-93), which proposes that changes in life events create stress that can be better managed through apt utilization of individual and social resources. If mismanaged or compounded by other risk factors, these stressors can lead to emotional and behavioral problems. In the Rwandan cultural context, stressors may be due to past genocide-related trauma in caregivers and communities and/or HIV/AIDS in the family, and can increase risk for problematic reactions including high risk behaviors, social isolation, or expression of anxiety and depression-like symptoms in children and adolescents. However, protective resources operating at different levels of the social ecology can help reduce the likelihood that mental health problems develop (94). Interventions that help improve utilization of individual, family, and social resources are therefore important for promoting child and family health and well-being. As evidenced in our qualitative data, the local resources available to HIV-affected families in Rwanda are significant; considered in light of the ecological stress-adjustment model, such natural sources of strength offer a starting point for intervention development.

In using natural strengths to improve stress-adjustment, the FSI, provides a lower-intensity, prevention-oriented mental health intervention that is rare in SSA (95, 96). It has tremendous potential for addressing the many familial, contextual, and social factors threatening child development in settings like Rwanda (11, 50, 97-102), and also presents a feasible approach to developing mental health services in this and other low-resource and culturally-diverse settings (103, 104). Compared to intense, short-term treatments requiring highly-trained personnel, long-term family-based programs to prevent mental health problems offer an "upstream" solution with the potential for integration within existing systems of care such as HIV-related services. Research has shown that prevention of mental health problems can help decrease the factors that aggravate poor outcomes by improving help-seeking, problem-solving, coping, and degree of community engagement (105)

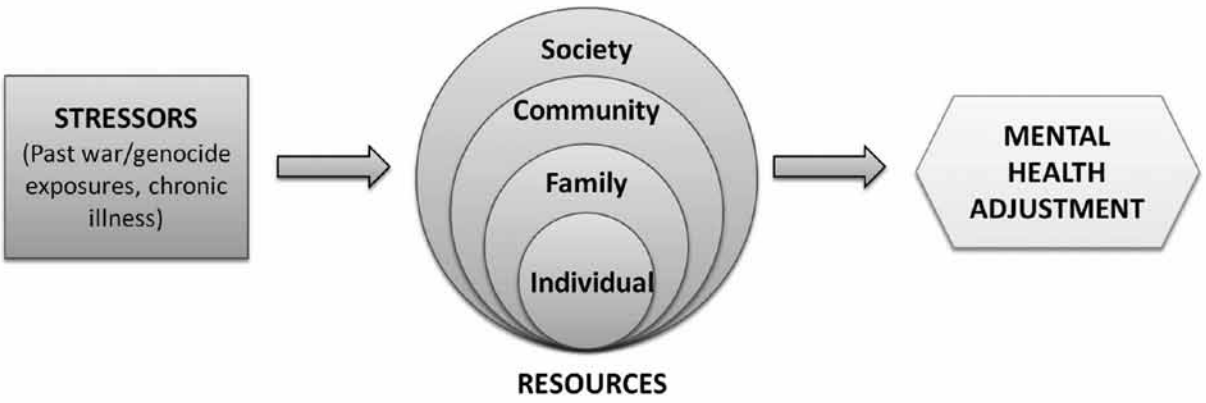


Figure 2. Ecological model of stress-adjustment

and suggests that these preventive programs can provide a first line of defense against mental health risks in families and children (106, 107). In one of the other few non-trauma focused intervention studies in Rwanda, Brown and colleagues (2009) found that strengthening the social supports available to youth-headed households via adult mentorship improved psychosocial outcomes among orphans (108). This particular study was successful in leveraging local community strengths to create a feasible, effective intervention, although focused on orphaned children and youth-headed households. Our FSI takes a similar approach to strengthening natural resources, with consideration given to a broad spectrum of family environments and situations and the potential to adapt the intervention, if proven effective, to many other forms of family adversity beyond HIV/AIDS, including family violence and concentrated poverty. A further innovation demonstrated by the FSI project is our approach to program evaluation. Rigorous development and validation of mental health measures, as well as incorporation of intervention participant exit interviews, are intended to facilitate robust feedback loops to improve intervention development over time. Given constantly-evolving health care system infrastructures and local needs, mechanisms for integration of feedback are critical to the development of flexible, responsive, effective interventions. Because the FSI-R has been developed in the context of a strong emphasis on local culture and terminology, we hope it will be immediately more engaging and feasible than importing other family based intervention models from other cultures. The foundational intervention, the FBPI was originally designed to be implemented by a wide range of mental health workers and a similar spirit is emulated in the FSI-R. Although initial feasibility trials of the FSI-R will be implemented by well trained and experienced mental health workers (to optimize our learning and ensure participant safety) we intend for the intervention to eventually be refined and implemented by well trained and supervised community health workers. Such an approach is aimed at building on the system of care and strong networks of community-based services being implemented by the Rwandan Government via District Hospitals, Community Health Centers and a growing network of mental health nurses and community health workers.

Conclusion

The collaborative, mixed-methods process for intervention development and evaluation described in this article provides a model for future cross-cultural and local work to develop mental health services for vulnerable children and families. It highlights how, despite high rates of exposure of children and families to armed conflict and chronic illness in sub-Saharan Africa (109), many children, youth and families rely on naturally-occuring protective resources to build resilience and persevere. Further, it shows that research which identifies and leverages these resources holds great promise for developing effective services that can help to improve caregiver-child relationships, promote effective coping, integrate vulnerable families with community networks, and engage with local health services. Such research can be performed with strong cultural input to enhance, feasibility, acceptability, and strong adherence to high ethical standards. Although services research needs may vary cross-culturally assessing and planning services to respond to unique forms of adversity in many settings can be addressed through the mixed-methods framework presented in this paper. Overall, evidence-based, culturally-informed, and holistic approaches to intervention development and evaluation have great potential to strengthen families and improve long-term outcomes in vulnerable children and adolescents.

References

1. Benjet C. (2010 July): Childhood adversities of populations living in low-income countries: prevalence, characteristics, and mental health consequences. Current Opinion in Psychiatry. ;23(4):356-62.
2. Cluver L, Orkin M. (2009): Cumulative risk and AIDS-orphanhood: Interactions of stigma, bullying and poverty on child mental health in South Africa. Social Science & Medicine. ;69(8):1186-93.
3. Cluver L, Gardner F, Operario D. (2009)Poverty and psychological health among AIDS-orphaned children in Cape Town, South Africa. AIDS Care. ;21:732-41.
4. Kinyanda E, Kizza R, Levin J, Ndyanabangi S, Abbo C. (2011): Adolescent suicidality as seen in rural northeastern Uganda: Prevalence and risk factors. Crisis: The Journal of Crisis Intervention and Suicide Prevention. ;32(1):43-51.
5. Betancourt TS, Agnew-Blais J, Gilman SE, Williams DR, Ellis BH. (2010 Jan) Past horrors, present struggles: the role of stigma in the association between war experiences and psychosocial adjustment among former child soldiers in Sierra Leone. Social Science & Medicine. ;70(1):17-26.
6. Maccoby EE, Martin JA. (1983): Socialization in the context of the family: Parent-child interaction. Mussen PH, Hetherington EM, editors. New York: Wiley;

7. Cluver L, Gardner F. (2009): The mental health of children orphaned by AIDS: a review of international and southern African research. Journal of Child & Adolescent Mental Health,19(1):1-17.
8. Bachmann MO, Booysen FL. (2003): Health and economic impact of HIV/AIDS on South African households: a cohort study. BMC Public Health. Apr 1;3:14.
9. Nampanya-Serpell N, editor. Social and Economic Risk Factors for HIV/AIDS-Affected Families in Zambia. AIDS and Economics Symposium; 2000 7-8 July 2000; Durban.
10. Cluver L, Gardner F, Operario D. (2008): Effects of stigma on the mental health of adolescents orphaned by AIDS. Journal of Adolescent Health.;42(4):410-7.
11. Betancourt TS, Rubin-Smith J, Beardslee WR, Stulac SN, Fayida I, Safren SA. (2011): Understanding locally, culturally, and contextually relevant mental health problems among Rwandan children and adolescents affected by HIV/AIDS. AIDS Care, 23(4):401-12.
12. UNICEF. Machel Study 10-Year Strategic Review: Children and Conflict in a Changing World. New York: UNICEF 2009.
13. UNICEF. The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS. 2004; Available from: http://www.unicef.org/aids/files/Framework_English.pdf.
14. Neugebauer R, Fisher PW, Turner JB, Yamabe S, Sarsfield JA, Stehling-Ariza T. (2009 Aug): Post-traumatic stress reactions among Rwandan children and adolescents in the early aftermath of genocide. Int J Epidemiol, 38(4):1033-45.
15. de Jong JT, Scholte WF, Koeter MW, Hart AA. The prevalence of mental health problems in Rwandan and Burundese refugee camps. Acta Psychiatr Scand. 2000 Sep;102(3):171-7.
16. Schaal S, Elbert T. (2006 Feb): Ten years after the genocide: trauma confrontation and posttraumatic stress in Rwandan adolescents. J Trauma Stress, 19(1):95-105.
17. Cohen MH, Fabri M, Cai X, Shi Q, Hoover DR, Binagwaho A, et al. (2009 Nov): Prevalence and predictors of posttraumatic stress disorder and depression in HIV-infected and at-risk Rwandan women. J Womens Health (Larchmt).18(11):1783-91.
18. Bolton P, Neugebauer R, Ndogoni L. (2002 Sep.): Prevalence of depression in rural Rwanda based on symptom and functional criteria. Journal of Nervous and Mental Disease. 190(9):631-7.
19. Dyregrov A, Gupta L, Gjestad R, Mukanoheli E. (2000 Jan): Trauma exposure and psychological reactions to genocide among Rwandan children. J Trauma Stress. 13(1):3-21.
20. Narang DS, Contreras JM.(2000 May): Dissociation as a mediator between child abuse history and adult abuse potential. Child Abuse Negl. 24(5):653-65.
21. Kaufman J, Zigler E. (1987 Apr): Do abused children become abusive parents? American Journal of Orthopsychiatry. 57(2):186-92.
22. Danieli Y. (1985): The treatment and prevention of long-term effects and intergenerational transmission of victimization: A lesson from Holocaust survivors and their children. In: Figley CR, editor. Trauma and its wake. New York: Brunner/Mazel. p. 295-313.
23. Baranowsky AB, Young M, Johnson-Douglas S, Williams-Keeler L, McCarrey M. (1998): PTSD transmission: A review of secondary traumatization in Holocaust survivor families. Canadian Psychology/Psychologie canadienne. 39(4):247-56.
24. Surkan P, Kennedy C, Hurley K, Black M. (2011): Maternal depression and early childhood growth in developing countries: systematic review and meta-analysis. Bulletin of the World Health Organization. 2011;89(8):608-15.

25. Dybdahl R. Children and mothers in war: An outcome study of a psychosocial intervention program. Child Development. 2001;72(4):1214.
26. Grunberg K. Contaminated Generativity: Holocaust Survivors and Their Children in Germany. The American Journal of Psychoanalysis. 2007;67:82-96.
27. Perlman SB, Camras LA, Pelphrey KA. Physiology and functioning: Parents' vagal tone, emotion socialization, and children's emotion knowledge. Journal of Experimental Child Psychology. 2008;100(4):308-15.
28. Traube D, Dukay V, Kaaya S, Reyes H, Mellins C. Cross-cultural adaptation of the Child Depression Inventory for use in Tanzania with children affected by HIV. Vulnerable Children and Youth Studies. 2010 2010/06/14;5(2):174-87.
29. Betancourt TS. Attending to the Mental Health of War-Affected Children: The need for Longitudinal and Developmental Research Perspectives. Journal of the American Academy of Child & Adolescent Psychiatry. [Editorial]. 2011;50(4):323-5.
30. Guarnaccia PJ, Lewis-Fernandez R, Marano MR. Toward a Puerto Rican popular nosology: nervios and ataque de nervios. Cult Med Psychiatry. 2003 Sep;27(3):339-66.
31. Lewis-Fernandez R, Guarnaccia PJ, Martinez IE, Salman E, Schmidt A, Liebowitz M. Comparative phenomenology of ataques de nervios, panic attacks, and panic disorder. Cult Med Psychiatry. 2002 Jun;26(2):199-223.
32. Stichick T. The psychosocial impact of armed conflict on children. Rethinking traditional paradigms in research and intervention. Child Adolesc Psychiatr Clin N Am. 2001 Oct;10(4):797-814.
33. de Jong JT, Van Ommeren M. Toward a culture-informed epidemiology: Combining qualitative and quantitative research in transcultural contexts. Transcultural Psychiatry. 2002;39(4):422-33.
34. Canino G, Alegria M. Psychiatric diagnosis - is it universal or relative to culture? Journal of Child Psychology and Psychiatry. 2008;49(3):237-50.
35. Hollifield M, Warner TD, Lian N, Krakow B, Jenkins JH, Kesler J, et al. Measuring trauma and health status in refugees: a critical review. Jama. 2002 Aug 7;288(5):611-21.
36. Alegria M, Takeuchi D, Canino G, Duan N, Shrout P, Meng XL, et al. Considering context, place and culture: the National Latino and Asian American Study. Int J Methods Psychiatr Res. 2004;13(4):208-20.
37. King E, De Silva, M., Stein A, Patel V. . Interventions for improving the psychosocial well-being of children affected by HIV and AIDS. Cochrane Database of Systematic Reviews 2009. 2009(2).
38. Betancourt TS, Bass J, Borisova I, Speelman L, Onyango G, Neugebauer R., et al. Measuring local instrument validity and reliability: a field-based example from northern Uganda. Social Psychiatry and Psychiatric Epidemiology. 2009 Aug;44(8):685-92.
39. Bolton P, Tang AM. An alternative approach to cross-cultural function assessment. Soc Psychiatry Psychiatr Epidemiol. 2002;37(11):537-43.
40. Collins PY, Patel V, Joestl SS, March D, Insel TR, Daar AS. Grand challenges in global mental health. Nature. 2011;472(7 July 2011):27-30.
41. Patel V, Flisher AJ, Nikapota A, Malhotra S. Promoting child and adolescent mental health in low and middle income countries. Journal of Child Psychology & Psychiatry. 2008;49(3):313-34.
42. Betancourt TS, Rubin-Smith J, Beardslee WR, Stulac SN, Fayida I, Safren SA. Understanding locally, culturally, and contextually relevant mental health problems among Rwandan children and adolescents affected by HIV/AIDS. AIDS Care, iFirst:1-12.
43. Betancourt TS, Meyers-Ohki SE, Stulac SN, Barrera AE, Mushashi C, Beardslee WR. Nothing can defeat combined hands (Abashize hamwe

ntakibananira): Protective processes and resilience in Rwandan children and families affected by HIV/AIDS. Social Science & Medicine. In press.

44. World Health Organization. Process of translation and adaptation of instruments. 2007 [cited 2010 June 30, 2010]; Available from: www.who.int/substance_abuse/research_tools/translation/.
45. Douglas S, Craig C. (2007): Collaborative and iterative translation: an alternative approach to back translation. Journal of International Marketing. 15(1):30-43.
46. Beaton D, Bombardier C, Guillemin F, Ferraz M. (2000): Recommendations for the cross-cultural adaptation of health status measures. Spine. 25:3186-91.
47. da Mota Falcão D, Ciconelli R, Ferraz M. (2003): Translation and cultural adaptation of quality of life questionnaires: an evaluation of methodology. The Journal of rheumatology. 30(2):379.
48. Van Widenfelt BM, Treffers PDA, De Beurs E, Siebelink B, Koudijs E. (2005): Translation and Cross-Cultural Adaptation of Assessment Instruments Used in Psychological Research With Children and Families. Clinical Child & Family Psychology Review. 8(2):135-47.
49. Brislin RW. (1970): Back-translation for cross-cultural research. Journal of Cross-Cultural Psychology. 1(3):158-216.
50. Betancourt TS, Meyers-Ohki SE, Stulac SN, Barrera AE, Mushashi C, Beardslee WR. (2011): Nothing can defeat combined hands (Abashize hamwe ntakibananira): Protective processes and resilience in Rwandan children and families affected by HIV/AIDS. Social Science & Medicine. 73(5):693-701.
51. Betancourt TS, Meyers-Ohki SE, Stulac SN, Barrera AE, Mushashi C, Beardslee WR. Using Mixed Methods to Plan, Assess, and Evaluate International Mental Health Programs for Children and Families Facing Adversity: The Development of the Family Strengthening Intervention (FSI-R) in Rwanda. In: Corbin J, editor. Children and families affected by armed conflicts in Africa: Implications and strategies for helping professionals in the United States: National Association of Social Workers Press; In press.
52. Peleg-Popko O, Dar R. (2001) Marital Quality, Family Patterns, and Children's Fears and Social Anxiety. Contemporary Family Therapy: An International Journal. [Article]. 23(4):465-87.
53. Solantaus T, Paavonen E, Toikka S, Punamäki R. (2010;Oct 2): Preventive interventions in families with parental depression: children's psychosocial symptoms and prosocial behaviour. European Child & Adolescent Psychiatry.
54. Barrett PM, Rapee RM, Dadds MM, Ryan SM. (1996): Family enhancement of cognitive style in anxious and aggressive children. Journal of Abnormal Child Psychology. 24(2):187-203.
55. Tamplin A, Goodyer IM. (2001): Family functioning in adolescents at high and low risk for major depressive disorder. European Child & Adolescent Psychiatry. 10(3):170-9.
56. Aguilar P, Retamal G. (2009): Protective environments and quality education in humanitarian contexts. International Journal of Educational Development. 29(1):3-16.
57. Aguilar B, Sroufe LA, Egeland B, Carlson E. (2000): Distinguishing the early-onset/persistent and adolescence-onset antisocial behavior types: From birth to 16 years. Development and Psychopathology. 12(02):109-32.
58. Campbell SB, Shaw DS, Gillion M. (2001 Aug): Early externalizing behavior problems: Toddlers and preschoolers at risk for later maladjustment. Development and Psychopathology. 2000;12(03):467-88.
59. Luthar SS, D'Avanzo K. Contextual factors in substance use: a study of suburban and inner-

city adolescents. Dev Psychopathol. 1999 Fall;11(4):845-67.

60. Luthar SS, Goldstein A. Children's exposure to community violence: Implications for understanding risk and resilience. Journal of Clinical Child & Adolescent Psychology. 2004;33(3):499-505.
61. Weine S. Family roles in refugee youth resettlement from a prevention perspective. Child Adolesc Psychiatr Clin N Am. 2008;17(3):515-32, vii-viii.
62. Campbell-Sills L, Cohan SL, Stein MB. Relationship of resilience to personality, coping, and psychiatric symptoms in young adults. Behav Res Ther. 2006 Apr;44(4):585-99.
63. Luthar SS, Brown PJ. Maximizing resilience through diverse levels of inquiry: Prevailing paradigms, possibilities, and priorities for the future. Dev Psychopathol. 2007 Summer;19(3):931-55.
64. Bayer J, Hiscock H, Scalzo K, Mathers M, McDonald M, Morris A, et al. Systematic review of preventive interventions for children's mental health: what would work in Australian contexts? Aust N Z J Psychiatry. 2009;43(8):695-710.
65. Shepard S, Dickstein S. Preventive intervention for early childhood behavioral problems: an ecological perspective. Child Adolesc Psychiatr Clin N Am. 2009;18(3):687-706.
66. Riley A, Valdez C, Barrueco S, Mills C, Beardslee W, Sandler I, et al. Development of a family-based program to reduce risk and promote resilience among families affected by maternal depression: theoretical basis and program description. Clin Child Fam Psychol Rev. 2008;11(1-2):12-29.
67. Messam T, McKay MM, Kalogerogiannis K, Alicea S, Hope Committee Champ Collaborative Board MHHC. Adapting A Family-Based HIV Prevention Program for Homeless Youth and Their Families: The HOPE (HIV prevention Outreach for Parents and Early adolescents) Family Program. J Hum Behav Soc Environ. 2010 Mar 1;20(2):303-18.
68. DeGennaro V, Zeitz P. Embracing a family-centred response to the HIV/AIDS epidemic for the elimination of pediatric AIDS. Glob Public Health. 2009;4:386 - 401.
69. Institute of Medicine. Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. In: Mrazek P.J., Haggerty RJ, editors. Committee on Prevention of Mental Disorders Division of Biobehavioral Sciences and Mental Disorders Washington, D.C.: National Academy Press; 1994.
70. Beardslee WR. Prevention and the clinical encounter. American Journal of Orthopsychiatry. 1998 Oct;68(4):521-33.
71. Beardslee WR, Gladstone TR, Wright EJ, Cooper AB. A family-based approach to the prevention of depressive symptoms in children at risk: evidence of parental and child change. Pediatrics. 2003 Aug;112(2):e119-31.
72. Beardslee WR, Wright EJ, Gladstone TR, Forbes P. Long-term effects from a randomized trial of two public health preventive interventions for parental depression. J Fam Psychol. 2007 Dec;21(4):703-13.
73. D'Angelo EJ, Llerena-Quinn R, Shapiro R, Colon F, Rodriguez P, Gallagher K, et al. Adaptation of the Preventive Intervention Program for Depression for Use with Predominantly Low-Income Latino Families. Family Process. 2009;48:269-91.
74. Llenera-Quinn R, Shapiro RL, Bravo M, Lora A, D'Angelo E, Beardslee W. Adapted manual for the Prevention of Depression in Families Program for use with Latino families. . 2006.
75. Podorefsky DL, McDonald-Dowdell M, Beardslee WR. Adaptation of preventive interventions for a low-income, culturally diverse community. J Am Acad Child Adolesc Psychiatry. 40(8):879-86.
76. Llenera-Quinn R, Shapiro RL, Bravo M, Lora A, D'Angelo E, Beardslee W. (2006): Adapted manual for the Prevention of Depression in

Families Program for use with Latino families. [Manual]. In press.

77. Larivaara P, Taanila A, Aaltonen J, Lindroos S, Vaisanen E, Vaisanen L. (2004): Family-Oriented Health Care in Finland: Background and Some Innovative Projects. Families, Systems & Health: The Journal of Collaborative Family HealthCare. Winter;22:395-409.
78. Trickett EJ, Espino SL. (2004 Sep): Collaboration and social inquiry: multiple meanings of a construct and its role in creating useful and valid knowledge. Am J Community Psychol. 34(1-2):1-69.
79. Israel BA, Schulz AJ, Parker EA, Becker AB. (1998): Review of community-based research: assessing partnership approaches to improve public health. Annu Rev Public Health. 19:173-202.
80. Israel BA, Schulz AJ, Parker EA, Becker AB, Allen AJr, Guzman R. (2003): Critical Issues in Developing and Following Community Based Participatory Research Principles. In: Minkler M, Wallerstein N, editors. Community-Based Participatory Research for Health. San Francisco: Jossey-Bass Publishers.
81. Wells K, Miranda J, Bruce ML, Alegria M, Wallerstein N. (2004 June): Bridging community intervention and mental health services research. Am J Psychiatry. 161(6):955-63.
82. Schaal S, Elbert T, Neuner F. (2009): Narrative Exposure Therapy versus Interpersonal Psychotherapy. Psychotherapy and Psychosomatics. 78(5):298-306.
83. Olij J. (2005): Trauma awareness, healing, and group counselling in secondary schools. Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict. 3(1):51-6.
84. Machel G. (1996): Impact of Armed Conflict on Children. New York: United Nations Contract No.: A/51/306.
85. Machel G. (2000): The Impact of Armed Conflict on Children: A critical review of progress made and obstacles encountered in increasing protection for war-affected children. International Conference on War Affected Children Winnipeg, Canada.
86. Betancourt TS, Williams T. (2008): Building an evidence base on mental health interventions for children affected by armed conflict. Intervention: International Journal of Mental Health, Psychosocial Work and Counseling in Areas of Armed Conflict. 6(1):39-56.
87. Beardslee WR, Gladstone TR. (2001 Jun 15) Prevention of childhood depression: recent findings and future prospects. Biol Psychiatry. 49(12):1101-10.
88. Beardslee WR, Hosman C, Solantaus T, van Doesum K, Cowling V. (2006): Supporting children and families of mentally ill parents: preventing transgenerational transfer of mental disorders. In: Hosman C, Jane-Llopis E, Saxena S, editors. Evidence-based prevention of mental disorders: Oxford University Press.
89. Caspe M, Lopez M. (2006): Lessons from Family Strengthening Interventions: Learning from Evidence-Based Practice. Cambridge, MA: Harvard Family Research Project, Harvard Graduate School of Education.
90. Bronfenbrenner U. (1979): The ecology of human development: Experiments by nature and design. Cambridge, MA: The Harvard University Press.
91. Lazarus RS, Folkman S. (1984): Stress, appraisal and coping. New York, NY: Springer.
92. Biddlecom A, Awusabo-Asare K, Bankole A. (2009 Jun): Role of parents in adolescent sexual activity and contraceptive use in four African countries. Int Perspect Sex Reprod Health. 35(2):72-81.
93. Bell CC, Bhana A, Petersen I, McKay MM, Gibbons R, Bannon W, et al. (2008 Aug): Building protective factors to offset sexually risky behaviors among black youths: a randomized control trial. J Natl Med Assoc. 100(8):936-44.

94. Lazarus RS, Folkman S. (1984): The Coping Process: An Alternative to Traditional Formulations. Stress, Appraisal, and Coping. New York, NY: Springer.
95. Staub E. Healing, (2005): Reconciliation, Forgiving and the Prevention of Violence After Genocide or Mass Killing: An Intervention And It's Experimental Evaluation in Rwanda. Social and Clinical Psychology. 24(3):334.
96. Onuoha F, Munakata T, Serumaga-Zake P, Nyonyintono R, Bogere S. (2009): Negative Mental Health Factors in Children Orphaned by AIDS: Natural Mentoring as a Palliative Care. AIDS and Behavior. 13(5):980-8.
97. Doku P. (2009): Parental HIV/AIDS status and death, and children's psychological wellbeing. International Journal of Mental Health Systems. 3(1):26.
98. Lester P, Rotheram-Borus MJ, Lee SJ, Comulada S, Cantwell S, Wu N, et al. (2006): Rates and predictors of anxiety and depressive disorders in adolescents of parents with HIV. Vulnerable Children and Youth Studies. 1(1):81-101.
99. Murphy DA, Greenwell L, Mouttapa M, Brecht ML, Schuster MA. (2006 Oct): Physical health of mothers with HIV/AIDS and the mental health of their children. J Dev Behav Pediatr. 27(5):386-95.
100. Bagilishya D. (2000 Sep): Mourning and Recovery From Trauma: In Rwanda, Tears Flow Within. Transcultural Psychiatry. 37(3):337.
101. Pham PN, Weinstein HM, Longman T. (2004 Aug 4): Trauma and PTSD symptoms in Rwanda: implications for attitudes toward justice and reconciliation. Jama. 292(5):602-12.
102. Zraly M, Nyirazinyoye L. (2010): Don't let the suffering make you fade away: An ethnographic study of resilience among survivors of genocide-rape in southern Rwanda. Social Science & Medicine. 70(10):1656-64.
103. Jordans MJD, Tol WA, Komproe IH. (2011): Mental health interventions for children in adversity: Pilot-testing a research strategy for treatment selection in low-income settings. Social Science & Medicine. 73(3):456-66.
104. Bower P, Gilbody S. (2005 January 1): Stepped care in psychological therapies: access, effectiveness and efficiency. The British Journal of Psychiatry. , 2005;186(1):11-7.
105. Saxena S, Jane-Llopis E, Hosman C. (2006 Feb): Prevention of mental and behavioural disorders: implications for policy and practice. World Psychiatry. 5(1):5-14.
106. Saxena S, Thornicroft G, Knapp M, Whiteford H. (2007 September 8- September 14, 2007): Resources for mental health: scarcity, inequity, and inefficiency. The Lancet. 370(9590):878-89.
107. Mwape L, Sikwese A, Kapungwe A, Mwanza J, Flisher A, Lund C, et al. (2010): Integrating mental health into primary health care in Zambia: a care provider's perspective. International Journal of Mental Health Systems. 4(1):21.
108. Brown L, Thurman TR, Rice J, Boris NW, Ntaganira J, Nyirazinyoye L, et al. (2009): Impact of a mentoring program on psychosocial wellbeing of youth in Rwanda: Results of a quasi-experimental study. Vulnerable Children & Youth Studies. [Article]. 4(4):288-99.
109. Office of the Special Representative of the Secretary General for Children and Armed Conflict. Ten Years On, Machel Review Cites Continued Abuse Against Children in Conflicts. 2007 [updated 17 October14 January 2008]; Available from: http://www.un.org/children/conflict/pr/2007-10-17167.html.

The Buddhist Practice Of Insight Meditation (Vipassana) And Its Possible Contribution To Healing Psychologically Traumatized Communities: Discussing The Case Of Uganda.

Jacob Waiswa
Research Associate, Peace and Conflict Center, Makerere University, P.O. Box 7062, Kampala. Uganda

AJTS JUNE 2011 2(1): 46-51

Introduction

Psychological trauma denotes a person's vulnerability and inability to cope with stress, even to the seemingly slightest challenges of life, as a result of any stressful event or events. This may lead to a dysfunctional mental and physical state in the person's interaction with others in the social, economic, cultural and spiritual environment.

When thus traumatized, it becomes necessary and natural for a person to decide which development or path to pursue to alleviate symptoms, as several options are available, in order to preserve life and maintain internal personal harmony and peaceful coexistence. Regardless of the individual's spiritual persuasion and contentment, they ultimately have to decide which philosophy or inclination that will best work for them. Today, Africans are often confronted with pressure to choose one or more religions among the many at any given time and space, albeit with difficulty , in order to achieve this internal peace. The quality of decisions made will determine the nature of results according to different influences and intensities on life of an individual or community. Therefore, it calls for critical thinking and analysis in order to make the right decisions.

Religion attempts to organize people towards attainment of spiritual expectations as pathways to achievement of peace in the present life and the life after. It attempts to organize people to achieve spiritual, mental, physical and social wellbeing. Religion calls upon people to form some kind of relationship with the Divine and to be bound by a covenant or set of rules in order to realize the goal of peace and harmony in life.

In Uganda, the dominant religions are Christianity (in the form of Catholicism and Anglicanism) and Islam. However, many people, in addition to these, also have some form of beliefs in African Traditional Religions (ATR) and practices, albeit disguised as culture. This creates the African co-existential duality as often seen in Pan-Africanist philosophy but often with considerable resistance to accepting other forms of religious practices. Pan-Africanism entails looking back to one's African origins with pride, confidence and high esteem, inspired by its rich heritage, to achieve success in all spheres of life. It seeks connections to ancestral reverence and wisdom.

Correspondence:
Jacob Waiswa
Peace and Conflict Center, Makerere University,
P.O. Box 7062, Kampala. Uganda
E-mail: jwaiswa@arts.mak.ac.ug

BUDDHISM

A review of old Buddhist writings shows that Buddhism had its roots in Black African ancestry as its genesis is connected to the Dravidian (black) Indians of South India whose ancestors can be traced to Africa (1, 2). Buddhism is an ancient practice of achieving and preserving wisdom, which seeks and facilitates the eradication of suffering, misery and disease in all beings with the aim of total liberation and happiness of the person (3,4,5). This is achieved through the Buddhist practice of insight meditation called VIPASSANA where the outcomes are as follows (3,4,5):

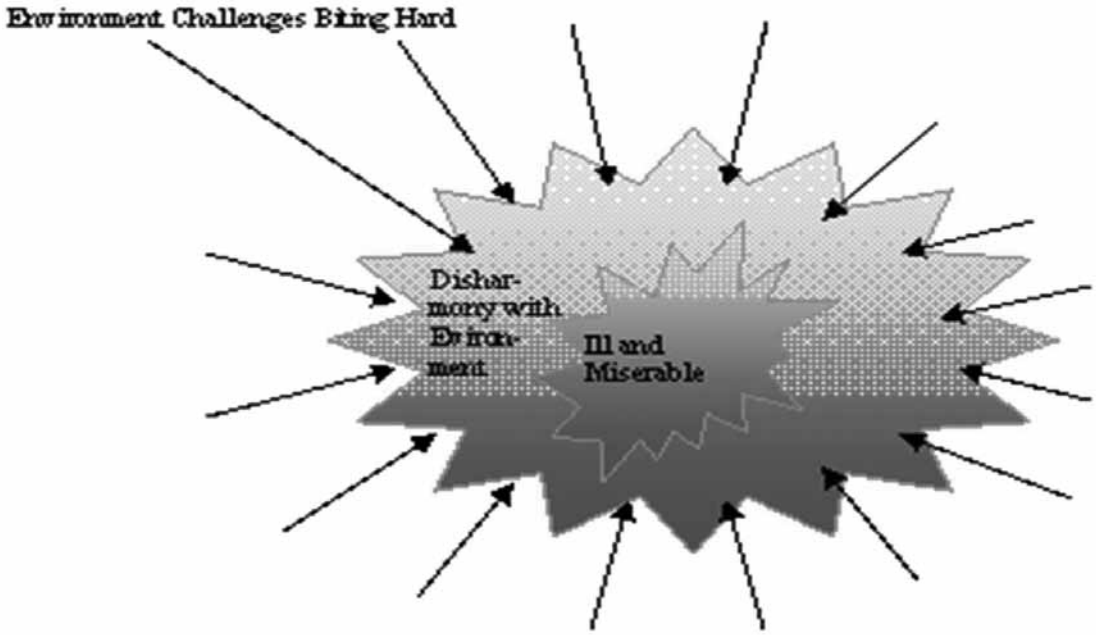
1. Observed masterly of the mind and actions: This is achieved through taming the ego and instinct to create a new and stronger sense of reality to replace the trauma-created stress and anxiety and instead create free conditions within an individual and his or her environment. Knee jerk reactions to stress are changed into slowness to react and to effectively arrest the tendency to crave, and form negative reactions. Vipassana helps one to create a sense of oneness with nature and with society; facilitates a mental alertness and eases efforts to let go, giving rise to calmness, contentment and relaxed states. This helps to avert tension states like migraine tendencies and greatly puts off anger towards others.

2. As one meditates, unfriendly behaviors are sharply and easily recognized as they come to the forefront (conscious from the unconscious). These are then ably substituted with positive dharma lessons on positive living with right attitudes towards nature and fostering of kindness to all beings and to appreciation of nature.

3. Supported by continued practice of the Vipassana technique, rightful thinking always determines rightful actions in the day-to-day life transactions. Practitioners of Vipassana meditation become peaceful amidst challenges of social change. They become full of love and humor in their interaction with family, friends, workmates and even enemies. Also at work, concentration and productivity become high.

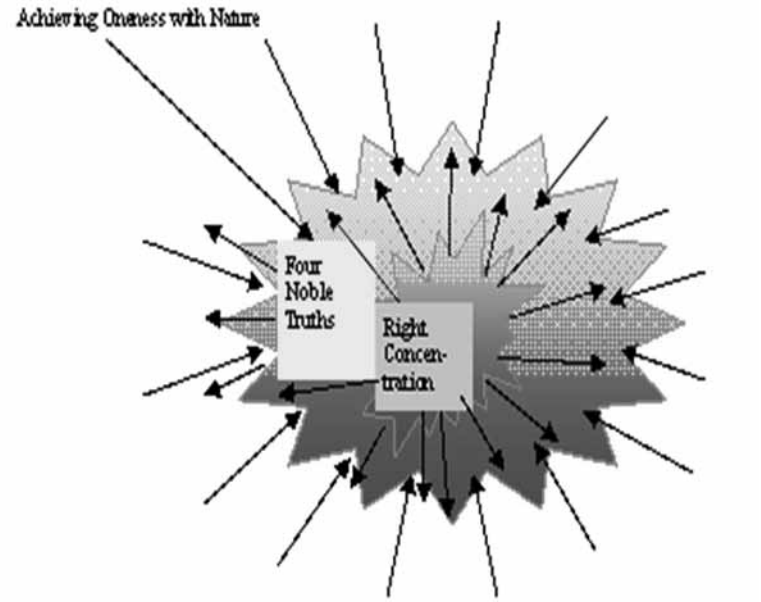
4. During the Buddhist practice of insight meditation, outcomes may vary among participants depending on the quality of each individual's response to instructions and understanding of the message about Buddhism. Meditation participants receive advice to continue doing it at home at least twice a day or in groups once a week. Announcements of new meditation opportunities around the world are made to perfect their meditation practice elsewhere. The following illustrations summarize these points.

ILLUSTRATION I: The Traumatized miserable individual



In Illustration I, the traumatized person is ill, miserable and in disharmony. The arrows show stresses all "shooting" at him/her. He/she has nothing from within him/her to neutralize or shoot back the arrows of stress.

ILLUSTRATION II: The individual During Insight Meditation (Vipassana) by applying dharma.



In illustration II, the traumatized individual is now in the process of insight meditation, Vipassana. As can be seen he/she is now garnering all inside resources to combat the incoming stress arrows and is "shooting" back through applying the principles of the "Four Noble Truths" and "Right Concentration" (dharma) hence neutralizing the tension/stress from within him/herself.

ILLUSTRATION III: An End To Suffering (Nirvana)

An end to suffering (Nirvana) is achieved after attaining inner peace and harmony with the environment.

From the first illustration, a traumatized individual has failed to cope with life. He/she is so vulnerable and helpless that s/he cannot help himself or herself. He or she fails to cope with the constant pressure from the environment and physiological stimuli. He or she is shattered!

From the second illustration, through the right meditative concentration, individual (s) begin to solve their problems by viewing the multiplicity of unsolved issues embedded in their lives and finding alternatives. They begin to see their problems differently and they watch them to continuously rise and vanish –until eventually they stop seeing, observing, feeling or cognitively thinking problems. They are simply free from them all. They begin to see the realities of life through the introduction the Four Nobel Truths and continue meditation practice at least twice a day.

From the third illustration, there is an incredible end to suffering of all sorts: individuals feel calm, very normal, relaxed, happy, peaceful and ready to share their joy.

OBSERVATIONS.

In a recent Uganda workshop on peace and reconciliation after war, the author introduced the concept of Buddhist Insight Meditation (Vipassana) as a possible approach to helping war-traumatized individuals. The author made the following observations in a multi-faith discussion group of Ugandan Africans after convincing some to embrace the Buddhist Insight Meditation (Vipassana) as their approach to helping war-traumatized individuals and create peace and reconciliation, while others remained in their mainstream religions.

1.**BUDDHISM**: The convinced devotees became very spirited and turned ritualistic although they viewed Buddhism as being non-religious or " a religion by choice". They saw it as a way of life but with amazingly positive outcomes to life-systems leading its practitioner to happiness as its final destination. Unlike the other mainstream religions (of Christianity & Islam), Buddhism was experiential. They felt that Buddhism had enshrined practical values, but was universal and yet recognizing diversity.It guided one to empirically undergo sustainable healing to attain a total state of wellness, rather than being merely a matter of believing. It was applicable to day-to-day-life bids to yield harmony for oneself and others.

They saw Buddhism as one way of empowering oneself in particular; that it psychologically helped traumatized people in general with the tool of objective decision-making, rather than fostering love-hate interactions, imaginations and emotions based on unproven beliefs. They saw the practice as most relevant to cases that allowed traumatized people to follow a healing program. They concluded, however, that the reception of Buddhism in Africa was still poor.

2. MAINSTREAM RELIGIONS . Here people gave many testimonies about healing and success.

i) Indeed believers in Islam, as was the atmosphere in the mosque, showed great feelings of acceptance from God which strengthened their relationship and continued adherence to the teachings of Prophet Mohammed. For these Moslems, the sin of torturing others was seen as terrible and feared. However, this did not apply when it was felt as a religious 'right' to organize assaults against non-believers or fellow Moslems whom they considered as having abused Islam or who did not believe in their cause (moderates). They also expressed strong views and intolerance about other religions whom they saw as "untruths". They had no non-confrontational or peace-loving advocacy. They had no room for compromise and did not see healing solutions to the subsequent psychological trauma except to pray to God to punish the perpetrators and to give heaven to the victims.

ii) For Christians, they saw the sinful nature of humans and only called for mercy and prayer for forgiveness for those who had sinned (torturers) but not humiliation from others or a sense of it within themselves. Christian actions and their belief system created calmness within an individual and caused relief from stress, anxieties and depression through messages of love, and assurance of healing and eternity. However, they too had no room for other religions which they considered false and asserted that only theirs was right. They often castigated un-Christian communities as unworthy spiritually whom they saw as sinners who would never go to heaven. That seemed to seed conditions for future conflict.

Regarding healing of traumatized victims, Christians often sang songs that carried the burdens of life, often attaining feelings of relief in the process. As an outcome, followers found a new kind of health in attending church services, especially those which were active in singing and dancing. That increased connectedness to their God. Unfortunately, that connection loosened by mid-week to necessitate re-fueling the next Sunday or Saturday. In addition, it was seen as a business to run churches for Christians and the owners became filthily rich at the expense of unsuspecting followers.

During conversion rituals for new entrants in their religions, both Christianity and Islam demonstrated intolerance and sharply divisive and verbally aggressive messages to each other that suggested potential seeds for future trouble. For example Moslems stressed that God was not the father of Jesus , arguing that he did not have biological attributes to do so, and they rubbished the resurrection story. On the other hand, Christians were quick to assume superior rights over inheritance of worldly and heavenly riches and preserved their stance that Jesus rose from the dead and was more powerful than Mohammed or any others (King of kings). Both religions used their scriptures to justify violence against fellow men, to degrade the environment, nature and nurse their own egos.

3. AFRICAN TRADITIONAL RELIGIONS. These espoused Pan-Africanism, arguing that God could not have sidelined Africans as human beings to discredit all their systems and relegate their practices and beliefs to Satanic practices. Pan-Africanism prevailed as based on strong respect attached to African traditions and healing approaches, even though with much infiltration of foreign religious cultures and Western liberal thinking with its limitations at the expense of traditional mystical African spirituality. Moreover,

many a Pan-Africanist were seen to make enemies of them-selves and to alienate poor Africans through mindless destruction of nature and the environment and marginalization of fellow Africans because of greed and differences based on ideology, tribe or ethnicity as has become of most of the Pan Africanist rulers and educated elites who became dictators and militaristic and plundered Africa. This was seen to have perpetuated wars and torture.

Regarding traumatized victims, many Pan-Africanists argued for traditional justice systems such as Ga cha cha courts in Rwanda, Mat-o-put in Northern Uganda, Kitawuluzi in Central Uganda, Kadhi (Islamic) courts in Zanzibar and Somalia etc. They also argued for the African existential humanism of Ubuntu, and asserted that reversal to and observance of such Traditional African systems of governance, justice and wisdom will be able to stop torture and wars and promote peace and reconciliation as had been the case before European intrusions in Africa with alien ideas.

DISCUSSION AND CONCLUSIONS

Many of today's African mainstream religions open healing doors for psychologically traumatized Africans. However, they do not provide exit routes for misery and suffering through individual empowerment with the masterly and diversity principle as promulgated in the Buddhist insight meditation of Vipassana. Instead, reeling trauma sequelae come back to haunt believers before the week's end and victims then look for the pastor's or mullah's residence for miracle healing and deliverance.

Mainstream religiosity seemed to have failed to tame evil in spite of the liberation message engraved in the various faiths. Instead, weeks, months or years of misery seemed to continue to rule victims. There was much emphasis on believing (or faith) to justify religious belonging rather than actions to placket healing.

Such inconsistencies between held beliefs and actions that occur deny Africans and people of African decent comprehensive and sustainable healing. Moreover, much western influences negatively affect today's African ways of life in terms of beliefs, attitudes, speech, clothing, food and music. African religious leaders and their followers have become more religious than the Europeans or Arabs who brought the foreign religions to them by adopting their (foreign) thinking and lifestyle. Thus decisions made in regards to what spiritual action a traumatized victim should take to heal him/herself is based on the faith and understanding that one belongs to but not on whether or not it could lead to attainment of a complete state of psychological and physical healing, security, wellness, peace, harmony and happiness for oneself and all other beings. Religious deceptions potentially deny psychologically traumatized Africans the opportunity to make informed decisions (from direct experience of mastering and understanding of nature) in the times of misery as the right path to effective and sustainable healing. The followers seem to only work to generate religious leaders' material wealth.

On the other hand, in the Buddhist approach of insight meditation (Vipassana) , individuals are put in position to listen and follow the inner self-empowering message of meditation as the healing program (3,4,5). Meditation is not just about the label "Buddhist thing" but a very helpful and effective practice to achieve a complete state of wellbeing regardless of the meditator's religious affiliation, race, gender tribe, origin, ethnicity or social class. Above all, the beneficiary develops a sense of collectivity with all elements of life and nature; which in a sustainable manner, becomes the catalyst to healing. In other words, Buddhist meditative healing (Vipassana) is real and complete. The individual must get rid of any negative conflicts in the mind that defeats perceptions about life (or body). This is done through meditation by applying dharma, otherwise, mixing feelings and thoughts about the various existing stresses blocks the effect of the meditation

on the person seeking healing. If this happens, there are different healing practices which can be used with evidenced benefits. These include 15 minutes group silence, contemplating, self imagery, positive reinforcement, and positive self-talk and masterly all accompanied by drills of physical exercise (6).

In conclusion, it would seem that to prevent misery and help the traumatized, Africans will do well to develop a mass-Buddhist philosophy with a mixture of African dualistic philosophy that makes up the dualism of today's Africans. This should include:

1. Ubuntu co-existentialism with strong Buddhist and African Traditional spiritualism, mysticism and ritual.

2. A belief in a Superior Theist/system/nature/ spirit, that finally puts right the wrongs and corrects those gone astray; that punishes wrong doers and rewards those who do good.

3. A belief in ourselves to be able to develop systems to defend ourselves from our never ending enemies and detractors who are armed to the teeth and who are ever ready to attack us at any given excuse.

REFERENCES

1. Ven Bhante Buddharakkita (2010): The African Buddhist Monk,
2. Metaphysics (2005): Buddha the African . http://zenbuddhism.tribe.net/thread/db64bf97-9e2b-4bb1-b27c-ee94bfff672a. Accessed November 2011
3. Knight, M.L. (1999): Morals in the Life Story of the Buddha: Lessons for Teaching Youths www.bps.lk/catalogs/international_%20catalogue.pdf . Accessed November 2010
4. Rahula, B. Y. (2009): The Meditation of Body & Mind. The Buddhist Association of the United States. NY, NY.
5. Goenka, S.N. (2007): The Discourse Summaries, Vipassana Research Institute, India
6. Nijel, BPG (1999): Nuba Wrestling: The Origin of Martial Arts Revealed! BFK Magazine http://www.nondomesticatedthinker.com/2010/03/african-origins-of-the-martial-arts-by-nijel-binns/ Accessed September 2010

The Prevalence Of Post Traumatic Stress Disorder (PTSD) Among Outpatients Attending A Hospital In Northern Nigeria

Duwap Makput[1]* **and Isa.B Rabbebe**
[1]Federal Neuropsychiatric Hospital, Maiduguri, Borno state, Nigeria.

Abstract
Introduction: *Considerable Literature shows that stress of high severity predisposes to mental illness. Some individuals who have experienced traumatic stress react in such a way that they manifest the features of Post Traumatic Stress Disorder (PTSD). Northern Nigeria has been the scene of considerable violence hence subjecting the population to much traumatic stress.*
Objectives: *To determine the prevalence of PTSD among out patients at the Federal Neuropsychiatric Hospital, Maiduguri (FNH-M) in Borno State, Nigeria following a crisis of ethno-religious violence.*
Methods: *During the period of the study, all consenting out patients who were present during the crisis period were administered the Post traumatic stress disorder check list questionnaire to check the prevalence of PTSD among the outpatient attendees of the FNH-M. To determine any predisposing or associated characteristics, their socio-demographic data were also obtained.*
Results. *A total of 256 respondents participated in the study, 130 males and 126 females giving a Male: Female ratio of 1:1. The mean age was 30 years. The overall prevalence of PTSD was 28%. More females (31.8%) developed PTSD than males (23.1%) giving a M:F ration of 1:1.4.*
Conclusion: *PTSD was common at the outpatient clinic of the FNH-M reflecting its commonness in Northern Nigerian society and affecting both genders but with a female preponderance. It was usually under diagnosed. This calls for the setting up of Psycho-trauma clinics in the post-conflict areas of Northern Nigeria.*
Key words: Northern Nigeria, prevalence, PTSD.
AJTS JUNE 2011 2(1): 52-55

INTRODUCTION

Stress is the tension, strain and pressure we experience when we face a demand or expectation that challenges our ability to cope or manage our life. Traumatic stress is an occurrence of piercing intensity that is outside the range of usual human experience and that would frighten almost anyone and threaten life or one's physical (bodily) integrity (1,2).

Post traumatic stress disorder (PTSD) is a clinical psychological disorder in which there is a profound painful emotional response to a stressful event or situation of an exceptionally threatening or catastrophic nature which is likely to cause pervasive distress in almost anyone (1,5,6). Historically PTSD has had various names including Shell shock Combat neurosis, Operational fatigue, Traumatic neurosis, Da costa's syndrome, Soldiers heart, Vietnam Syndrome and recently Gulf war syndrome all reflecting the common association of PTSD to war (combat) exposure. (5,6)

Regarding its aetiology, the presence of a stressor is necessary for the development of PTSD. Man made events e.g assault, bombings, armed robbery, ethno-religious violence etc may predispose to it. (2,7) Natural disasters such as road traffic accidents, floods, fires, volcanoes, mud slides, earthquakes and tsunamis have all been implicated as stressors causing PTSD (5,6).

The risk factors for the development of PTSD include prior victimization e.g childhood trauma, personality traits e.g paranoid or dependent personalities and genetic factors. Others include extended exposure to the event, severity of the event, poor support system, and sustaining physical injury by the event as well as chronic and frightening medical conditions such as HIV/AIDS or cancer (4, 5, 6).

Clinical features of PTSD

The clinical features of this disorder may begin soon after the traumatic event when it's called Acute Stress disorder (1). Sometimes however symptoms occur much later, about six months, hence the division between Acute and Delayed PTSD (1, 4, 5 & 6). DSM IV-TR diagnostic criteria for PTSD stipulate that symptoms must be of at least 30 days duration (1).

The symptom clusters are usually divided into 3 groups (1):-

***Correspondence:**
Duwap Makput
Federal Neuropsychiatric Hospital, Maiduguri, Borno State, Nigeria.
E-mail:harrymakput@yahoo.co.uk

A) Hyper-arousal B) Intrusions (Re-experiencing) C) Avoidance

In the hyper-arousal group of symptoms are persistent anxiety, irritability, insomnia, exaggerated startle response and poor concentration. Intrusion or Re-experiencing symptoms include intensive intrusive imagery (flashbacks) as well as thoughts, smells or sounds associated with the event. The avoidance cluster of symptoms includes avoidance of reminders of the event, detachment, emotional numbness and diminished interest. Sometimes affected individual fail to remember some (crucial) aspects of the traumatic experience (1,5,6)

PTSD diagnostic criteria as set out in DSM IV-TR (1) are more elaborate than the ICD 10 ones where the symptoms are categorized into groups A to F. In both classifications, a duration of disturbance of at least 1 month is required and it must cause clinically significant distress or impairment before a diagnosis can be made. Therapies for PTSD are varied but include antidepressant medications, anxiolytics as well as various psychotherapies including Cognitive Behavioral Therapy (CBT) and exposure therapy (3, 4, 5, 6).

Background

This study became necessary because of the violent events that occurred in the city of Maiduguri in Borno State, Northern Nigeria which experienced violent religious conflicts with nights of gunshots that resulted in the death of hundreds of people in one night. People woke up to find burnt residential houses, places of worship, security offices, prisons etc. This crisis saw many people injured while heaps of corpses littered in the streets of Maiduguri the night after the violent conflict.

Many days of fierce fighting in the town followed during which people remained fearful and looked themselves up indoors for several days. The markets, schools, banks etc remained closed. People experienced acute food and water shortages and palpable fear and apprehension. This devastating experience made many mental health workers weary of people developing PTSD. The objective of this study therefore was to determine the prevalence of PTSD among patients attending an outpatient clinic in a hospital in Maiduguri City in Northern Nigeria, which was the scene of much violent social and religious conflicts. The socio-demographic characteristics of the respondents were collected as possible correlates of those patients who developed PTSD.

Methodology.

This study was a descriptive, cross sectional study. After obtaining ethical clearance, all consenting patients who came to the out- patient department of the FNH-M hospital in October, 2009 were recruited for the study. Those who were exposed to the traumatic events were selected and administered the PTSD symptom Check List , PCL (1, 8). Their socio- demographic data were also obtained.

The PCL is a 17- item self report questionnaire in which respondents rate the traumatic symptoms they experience in terms of frequency /severity on a Likert- type scale ranging from the least i.e 0=not at all; to the most severe i.e. 5= extremely. The PCL measures the 17 DSM IV-TR symptoms of PTSD (1). It can serve as an instrument for screening and diagnosis of PTSD in communities. The scores range from 17 to 85 and a diagnosis is made by determining whether an individual met DSM-IV-TR symptom criteria for PTSD. Before a diagnosis is made, the individual must have the following scores: At least one "B" item (Q1- Q5); three "C" items (Q6-12), at least two "D" items (Q13-17). Only responses rated from "3" to "5" are counted as present or positive (1, 8)

The data was analyzed using the statistical package for social sciences (SPSS).

Results.

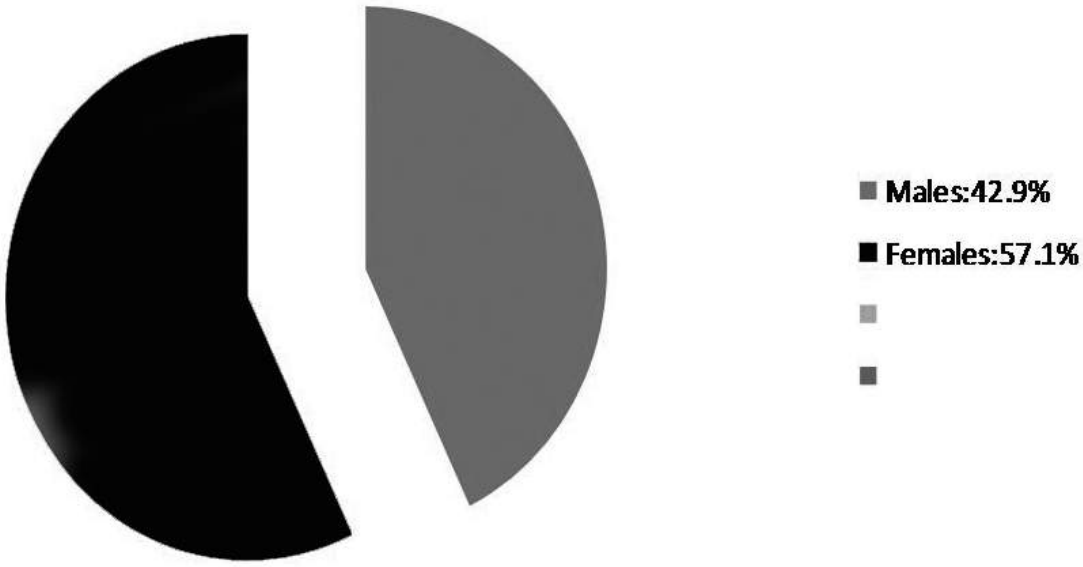
A total of 256 respondents out of a total of 261 (98.1%) eligible people participated in the study. Both males and females were very willing to participate giving a high response rate of 98%. Their ages ranged from 14 years to 59 years with a mean age of 30 years. There were 130 males which constituted 51% of the respondents and 126 (49%) females as shown in the figure below, giving a Male: Female ratio of 1:1

Prevalence of PTSD:

Of the 250 respondents, 70 (28%) developed PTSD. Of the 130 males who participated in the study, 30 (23.1%) developed PTSD, compared to 40 (31.8%) of the 126 females. Thus of the 70 total number of participants who developed PTSD, 30 (42.9%) were males and 40 (57.1%) were females. Therefore, in terms of PTSD prevalence by gender, more females developed PTSD giving a M:F ration of 1:1.4. Figures I and II illustrate these points.

Fig. I: Sex Distribution Of Respondents

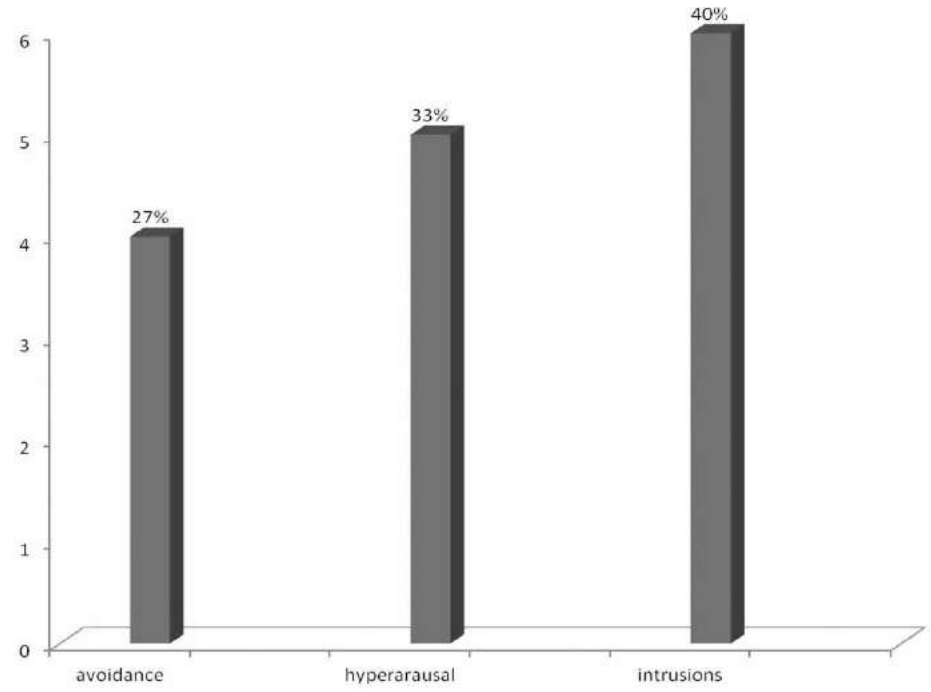
Fig II: Prevalence Of PTSD By Gender



PTSD symptom cluster

The most common symptoms were intrusive thoughts (40%) which could be described as the Re-experiencing phenomena. This was followed by Hyperarousal symptoms (33%) and lastly were the avoidance symptoms at 27%. Figure III below illustrates these points.

Fig. III: Bar graphs showing PTSD symptom clusters among the respondents.



Discussion.

A substantial number of people when exposed to a very stressful event develop Post traumatic Stress Disorder or PTSD (1, 4, 5 & 6). In this study, the prevalence of PTSD in the outpatient clinic of FHN-M in Northern Nigeria was 28%. This disorder is often under diagnosed in our environment and was hitherto thought to be rare in this environment. Males are known to be more resilient in times of stress as such, this may account for the lower prevalence of PTSD among males in this study compared to females.

The significance of the high PTSD prevalence rate is that in Northern Nigeria,1/3 (of the FHN-M out patients) had PTSD making it a very common diagnosis. This calls for the establishment of psycho-trauma clinics in every regional hospital in Northern Nigeria due to the frequent violent conflicts in that part of Africa.

Secondly, unwanted intrusive thoughts (re-experiencing) were a common symptom in Northern Nigeria. These worrisome thoughts often lead to Depression (and Suicide) which is the most common disorder associated with PTSD hence calling for African hospitals to focus on building Mental Health clinics in district Hospitals, due to the common occurrence of traumatic events in Africa.

Lastly females out numbered males in developing PTSD suggesting a need to develop gender – stratified interventions in Post-conflict Mental Health Care. This may also be because women may have had prior traumatic events such as domestic violence before the violent riots hence being predisposed to developing PTSD (4).

Conclusion

Post-traumatic Stress Disorder (PTSD) is common in Northern Nigeria, the scene of much religious violence, at a rate of 28% in the outpatient clinics. More females were affected than males in the ratio of 1:1.4. Lastly, most of the respondents were young with a mean age of 30 years, an age of utmost economic production. This calls for setting up mental health services to address trauma in every Post-conflict district in Nigeria.

References

1. American Psychiatric Association (1994): Diagnostic and statistical manual of mental disorders. 4th Edition DSM IV-TR. APA., Washington.
2. Burke L (2002): The consequences of truth; Post traumatic stress in new South Africa in transition Pg. 2-4
3. Davidson J (1992): Drug therapy for Post-Traumatic Stress Disorder: British Journal of Psychiatry 160:309-314.
4. Freedman SA, et al, (1999): Predictors of chronic Post-Traumatic Stress Disorder: A prospective study. Bjp 174:353-359.
5. Post-Traumatic Stress Disorder. In Synopsis of Psychiatry 7th ed. Kaplan & Saddocks, 1994 pg. 606-611.
6. Post-Traumatic Stress Disorder: In Oxford Textbook of Psychiatry, 3rd ed. Gelder & Mayou, Oxford University Press, 1996.
7. Ramsy R, Gorst-Unsworth C, Turner S (1993): Psychiatric morbidity in survivors of organized state of violence including torture: A retrospective series, BJP 162:55-59
8. Sundin C: Horowitz M, (2002): Impact of events scale. Psychometric properties. BJP 180:205-209.

Psychological Manifestations Of Nodding Syndrome In Northern Uganda: A Case Report

Musisi S[1]*, **Nakimuli-Mpungu E**[1], **Akena D**[1], **Bangirana P**[1], **Kinyanda E**[2],
[1]Department of Psychiatry, School of Medicine, Makerere University College of Health Sciences.
[2]MRC/UVRI Uganda Research Unit on AIDS.

AJTS JUNE 2011 2(1): 56-57

INTRODUCTION

Nodding Syndrome (NS) affects thousands of children in war-affected Northern Uganda and South Sudan (1). Characterized by head nodding and convulsions when eating, children are reported to suffer mental retardation and stunted growth. There is no known cause or cure. We report one of eight treated cases of NS referred from Kitgum District Hospital in Northern Uganda to Mulago National Hospital; seven of whom recovered. All the eight cases had extensive psycho-trauma histories.

The Case: A 14-year-old boy presented with a 10 year history of spells of " unresponsive staring, on-and-off generalized body tremors and nodding" but no loss of consciousness. The last of 6 children, he had lived and grown up in Internally Displaced People's (IDP) camps with his family. At age of four he witnessed his father being shot dead by rebel soldiers and his older brother abducted (and later killed). Rebels frequently attacked the IDP camps. He witnessed many people killed. Since then, he suffered "staring and fainting" spells, which were triggered by flashbacks of those traumatic events. Gradually, he stopped communicating, withdrew from family and friends and stopped attending school. He slept poorly with frequent nightmares, waking up feeling weak and sickly. He lost appetite and weight, eating one meal every two days. He became wasted and could not stand or walk but just stooped (nodding) and had to be supported by his mother (Figure I). At the district hospital, he was diagnosed with NS and treated with anticonvulsants, dewarming and ivermectin for presumed epilepsy, helminthiasis and/or onchocerciasis respectively. There was no improvement. No psychiatric assessments or treatments were tried.

At Mulago hospital, physical examination was remarkable for generalized body weakness, wasting, stunted growth, poor motor coordination and inability to walk. He was severely undernourished and had thin silky hair. He weighed 30 kg, at a height of 150cm and a mid-arm circumference of 16.8cm. Neurological examination was unremarkable. Mental State Examination revealed severe psychomotor retardation, reduced speech, lack of interest in surroundings and depressed mood without suicidal ideation. His thoughts were connected. He had no delusions or hallucinations. He had cognitive impairment. Extensive laboratory investigations only showed low serum creatinine and eosinophilia. The Electroencephalogram was normal. His brain CT-scan showed mild global brain cortical atrophy consistent with chronic malnutrition. EEG showed no epileptiform activity.

The psychiatric diagnoses were Complex Post-Traumatic Stress Disorder (PTSD) and severe chronic depression with complications of chronic under-nutrition. He was started on Imipramine 50mg nightly and supervised feeding. Mother and child received family supportive therapy (counseling). After 4 weeks of treatment, patient had a brighter mood with smiles, initiated conversation, played and ate 2 full meals daily. The nightmares stopped. He slept well. He was able to walk with support and the tremors decreased. There was no "nodding" noted. Five weeks after admission, he was discharged back to his district hospital, as improved, with instructions to continue the prescribed treatment.

Discussion: Extensive local and international research in NS for biological or environmental causative agents have been fruitless (1). This case suggests the possibility that "Nodding Syndrome" could be a cultural presentation of the psychological effects of protracted/repeated mass war-trauma in children in Northern Uganda/South Sudan. Earlier investigators

***Correspondence:**
Seggane Musisi FRCP(C). Department of Psychiatry, School of Medicine, Makerere University College of Health Sciences.
Email: segganemusisi@yahoo.ca

FIGURE I: Child With Nodding Syndrome Supported By His Mother

reported on severely traumatized children especially with parental/attachment loss who, initially, exhibited anxious behaviors with feelings of helplessness and hopelessness (2). This was followed by profound depression, social detachment and withdrawal, failure to eat with resultant failure to thrive, stunting, wasting and severe malnutrition or marasmus (2,3). This case demonstrated these complex psychological processes combined with somatization and dissociation, which transcended simple PTSD (4)

We conclude that NS could be a cultural presentation of complex PTSD or Developmental Trauma Disorder (DTD) in children complicated by severe and prolonged depression with total anhedonia and anorexia resulting in wasting and stunted growth (2,3,4,5,6). To our knowledge, no research on DTD has been carried out on war-traumatised children in Northern Uganda. Future research should investigate cultural expressions of the psychological effects of repeated trauma in children living in conflict/post-conflict communities and possible bio-psycho-social interventions for complex PTSD/DTD in them.

References

1. Wadman M (2011): African outbreak stumps experts. Nature 475:148-9.

2. Linn L (1980): Clinical Manifestations of Psychiatric Disorders. In Kaplan HI, Freedman AM, & Saddock BJ (Eds) Comprehensive Textbook of Psychiatry. Vol 1, 3rd Edition, Williams & Wilkins Co. Baltimore, MD, USA. Ch. 13 pp 990-1034

3. Herman JL (1992): Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma. Journal of Traumatic Stress, VoL 5, No. 3,

4. Van Der Kolk BA (2005): Developmental Trauma Disorder. Towards A Rational Diagnosis For Chronically Traumatized Children. Psychiatric Annals, 35, 401–408.

5. Van Der Kolk, BA (2007): The Developmental Impact of Childhood Trauma. In Kirmayer LJ, Lemelson R, And Barad M (Eds.), Understanding Trauma: Integrating Biological, Clinical And Cultural Perspectives (Pp. 224–241). New York: Cambridge University Press.

Guidelines to Authors

General instructions:
Submit original and two copies of the manuscript to: Editorial Secretariat , African Journal of Traumatic Stress, Department of Psychiatry, School of Medicine, College of Health Sciences, Makerere University P.O. Box 7072 Kampala, Uganda Email: ajts@gmail.com. The AJTS has no charges for papers accepted for publication. Papers published in the Journal should be evidence based and should have relevance to trauma. They can be research papers, reports, reviews, personal stories short communications or news worthy briefs. Manuscripts should be typewritten on white A4 paper using font size 12, double spaced and should not be more than 15 pages excluding references, tables, graphs, pictures or charts with wide margins (2 cm) and line numbered where possible.

Title: Should be brief and reflect the main theme of the paper. It should be less or equal to 15 words.

Authors: Names should appear below the title and below which the address should be typed.

Abstract: An Abstract in English should, if possible, be accompanied by French translation and Vice Versa. It should include key words, arranged alphabetically with one the first letter of the first key word capitalized. Key words should be separated by commas. Abstracts should be limited to a maximum of 250 words and should contain salient features of the study, briefly indicating Title, Introduction, Objectives/aim, Methods, Results and main Conclusions. Single solid lines should separate the by-line material from the Abstract and the Abstract from the main text.

Text: should appear in the following order: Title (maximum 20 words), Authors and their adresses, Abstract, Introduction, Methods/Methodology, Results/ findings, Discussion, Conclusion, Recomendation and policy implication where applicable, Acknowledgement(s) and twenty or less reference listings should follow Vancouver or Boston styles. Main section headings should be bold, centred and of uppercase letters. Do not underline the title or section headings. Subsections should also be bolded and when included only the first letter of the subsection should be capitalized. Use SI units of measurement and undeline all Latin words and scientific names. Use numerals before standard units of measurements e.g. 3g, 9 days, 36 hr: otherwise use words for numbers one to nine and numerals for large numbers. Non standard abbreviations should be avoided and where used, they should be explained at their first mention.

Introduction: Provide a survey of literature, Aims/ objectives and clearly justify the need for the study.

Methods/Methodology: This should be informative enough to enable readers to interprete the results obtained. Particular attention should be paid to the design, analysis and statistics. References for the methods used should be included.

Results: Should be concise. Avoid reproducing information already in tables.

Discussion: This section may be combined with results but generally should be separate. It should indicate clearly the significance and implications of the results obtained. Inferences and opinions should be distinguished from facts and should not duplicate results except to introduce or clarify points. Reference should be made to published literature.

Acknowledgements: Financial contributors, pre-paper reviews etc deserve acknowledgement.

References: Only articles or books published or are in press may be cited. Where need be, copies of the publishers' letter of acceptance should accompany all such citations. The references should be arranged sequentially by numbers (Vancouver style) or alphabetically (Boston style).

Authors should be referrred to in the text by name and year eg: (H.S Wako and M. Mukasa, 2001). Role of higher education in the Third World. Curent Sciences 81(8)868

If there are more than 3 authors quote only 3 and put et al and leave out the rest. Within the text, references should be given as; Lin and Liu (2000) and if many citations cite as Okello (1981), Otim (1993).

For books list as: Smiths G. (1987). Changes in composition of pathogen populations caused by resistance to fungicides. In Population of plant pathogens, their dynamics and genetics. Cook M.S and Cohen, C.E (Eds), pp 227-237. Blackwell Scientific Publications, Oxford.

Personal communication may be cited only in the text, giving names, date and institution or organization of source of information.

For websites: Kariuki

T. (1997). Report on the Joint JSPRS Commission III/IV Workshop '3D Reconstruction and Modelin gof Topographic Objects, Stuttgart, Germany. http://www.radig.informatic.tu-muenchen.de/ISPRS/WG-114-1V2-Report.html (accessed 28 March 2005).

Tables and figures: Tables and figures should be self explanatory, without reference to the text or other tables and figures. Captions should be brief but adequately describe contents. The word Table should be in Upper case letters and should be numbered with arabic numerals. Figure captions should be typed on a separate sheet of paper. In the text spell out the word Table but abbreviate Figure to Fig. Capitalize the first letter of table column and row headings. Footnotes are designated with supersript lowercase letters.

Graphs should be boxed and cordinates and abscissions marked with index lines. Pictures and illutrastraions may be in black and white or colour and of a size that allows reduction of up to 50%.

Paper revision: An author receiving editorial recommendations for revision should submit the revised manuscript within 4 weeks otherwise longer intervals will be treated as new manuscripts.

Gully page proofs will normally be sent to the author for correction if time permits.

For style and format, authors are advised to consult the most recent issue of African Journal of Traumatic Stress.

Peter C. Alderman

PSYCHOTRAUMA CONFERENCE

PETER C. ALDERMAN FOUNDATION

THE 5th PCAF PAN-AFRICAN PSYCHOTRAUMA CONFERENCE

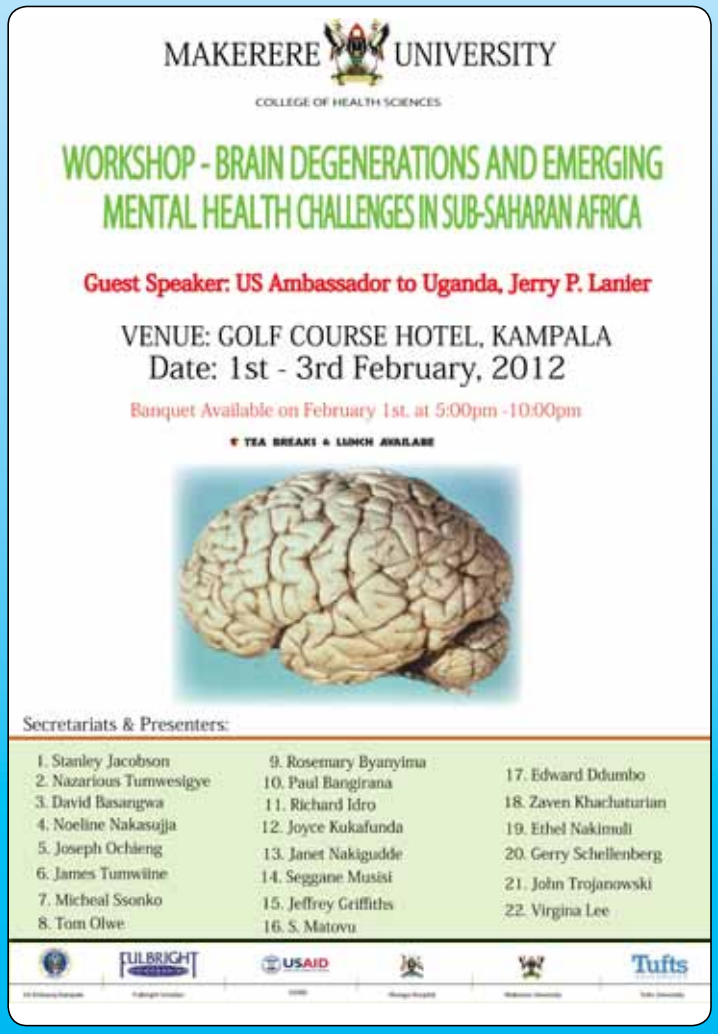
THEME: REFUGEES AND PSYCHOTRAUMA IN AFRICA

VENUE: THE MWALIMU NYERERE MEMORIAL ACADEMY
http://www.mnma.ac.tz/

DATE: 16th – 18th July 2012 – Conference days
19TH – 20TH FIELD VISIT TO CHOGO

CONFERENCE SECRETARIAT (TZ):

Chairman: Dr Frank Masao.	drfmasao@yahoo.com	Tel +255 754 288 673
Co-chair: Prof. Gad Kilonzo.	gadk2004@yahoo.com	Tel +255 784 11 59 62
The Secretary: Dr Kissah Mwambene.	dr_kebem@yahoo.com	Tel: +255 784 528295
Co-secretary: Dr Fausta Phillip.	philipfausta@yahoo.com	Tel: +255 784 70 62 61
Recorder: Dr Saidi Kuganda.	kuganda05@yahoo.com	Tel +255 783 32 88 44



Makerere University
College of Health Sciences
P.O.Box 7072
Kampala, Uganda