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Little is known about the usefulness of psychiatric concepts and psychotherapeutic approaches for refugees who have experienced severe traumatic events and continue to live in stressful and potentially dangerous conditions in refugee settlements. The central goal of the Nakivale Camp Mental Health Project is to establish the usefulness of short-term treatment approaches when applied by local paramedical personnel in a disaster region.
In a randomized controlled clinical trial, the efficacy of Narrative Exposure Therapy (NET) vis-à-vis Supportive Counselling has been tested, when applied by trained paramedical personnel from within the same refugee community. Here we demonstrate the feasibility of such an approach and detail the methods and strategy for it. The project also included an epidemiological survey to ascertain the prevalence of PTSD among refugee adolescents and adults alike. Consistent with other investigations, the demographic survey revealed a high prevalence of chronic PTSD ranging from 31.1% in the Rwandan to 47% in the Somali population; even though traumatic events had on average taken place more than 9 and 11 years earlier in each case respectively. Diagnostic validity was assured using expert clinical interviews.
The significant social and work-related dysfunction, a disabling consequence of PTSD, does not only impact on the life of the affected individual. Communities where a significant percentage of members are psychologically affected by past human rights violations, atrocities and war, are held back in their recovery process at many levels. Therefore mental health programmes with workable guidelines on how to treat posttraumatic symptoms, based on solid scientific research with proven effectiveness and feasibility, in particular cultural settings, must become a humanitarian priority.

Keywords: Psychotrauma, PTSD, Refugee, Camp, Counselling, NET, organised violence, Somali, Rwanda

Background

Forced migration has become one of the biggest challenges of the 21st century.
According to the United States Committee for Refugees (USCR) World Refugee Survey, worldwide there are over 13 million refugees and asylum seekers. In addition, over 21.8 million people are internally displaced within their own countries. In total, 34.8 million people are uprooted, with 4.28 million newly uprooted people in the year 2002 alone (United States Committee for Refugees, 2003). On no continent are these numbers greater than in Africa.
Uganda, the smallest of the three countries comprising East Africa, has had a long history of armed conflict, but has been in a state of relative peace for the past 17 years. Whereas Ugandans were themselves

refugees all over the world, they are now themselves host to over 220,000 refugees fleeing from conflicts in the Sudan, Congo, Rwanda, Burundi, Eritrea, Ethiopia, and until September 2003, even Kenya.

The consequences of violence and forced migration include the physical, educational, social, familial and the psychological. In addition to being nutritionally challenged, physically unhealthy, economically disadvantaged as well as displaced, refugees and other forced migrants may also suffer from often-repetitive traumatising experiences. Common among the mental health consequences of conflict and flight are Disorders of Traumatic Stress[2].

Trauma is significant because it precludes normal functioning in its victims, such that even in the event that they do reach a safe refuge and have the basics for a more or less normal life, they are unable to consolidate their resources in order to rebuild their lives. In addition, traumatised migrants may resort to substance abuse as self-medication, and may be aggressive or violent as a result of their symptoms. All such acting-out behaviour may compound existing political, social, community and familial difficulties.

Undoubtedly, psychological intervention to alleviate the symptoms of trauma is a first order of business especially since the prevalence of trauma-related disorders is exceptionally high among war-torn populations (e.g. Schauer et al., 2003b; Karunakara et al., 2004; De Jong et al., 2001; Mollica et al., 1993; Mollica et al., 1999; Somasundaram & Sivayokan, 1994). A large percentage of functionally impaired trauma victims is presumed to significantly slow down the affected community and to compromise its ability to recuperate from its conflict and conflict-related problems.

It is regrettable enough when adults are so incapacitated by the clinical consequences of their traumatic experiences that they are economically improvident and non-functional as parents or community members, but it is positively tragic when traumatised children and adolescents are so disturbed as to be unable to benefit from schooling and other skill-building opportunities - even when these exist. This further diminishes their ability to compete in an already challenging environment. This is a valid concern because clinically traumatised children and adolescents form a significant percentage of the refugee population.

In many refugee camps in Uganda, the United Nations High Commissioner for Refugees (UNHCR) as the custodian body for refugees caters for their safety, and provides basic food aid. The Red Cross provides basic health care and basic education for refugee children - at least up to primary school level. There have been, however, little consistent refugee mental health intervention.

In this paper, we present an approach to implement large-scale mental health assistance in a refugee camp by providing education and training about mental health and trauma to a selected group of refugees. We aim to demonstrate that it is possible to successfully educate socially intelligent and empathic laypersons to offer a short-term treatment to their compatriots. It is our experience that this treatment is highly requested by traumatised refugees, who form a significant proportion of the current population in the Nakivale camp. The work was performed under the umbrella of *vivo*, an international Non Governmental Organisation (NGO) with a local branch in Uganda.

The Nakivale Refugee Camp

Nakivale Refugee Camp (Figure 1) is one of

the eight official refugee camps in Uganda. It is situated in South-western Uganda 60 kilometres from Mbarara, the third largest town in Uganda. Nakivale settlement is also one of the oldest in Uganda, having already been in existence in 1952. It was host to the Rwandan Tutsi refugees who fled from the 1962 ethnic conflict in Rwanda. Originally 80 square kilometres in size, the settlement has now been reduced to about 42 square kilometres.

Nakivale currently (in 2003) hosts 14,400 refugees. Of these, 12,000 are Rwandan Hutu refugees who fled from the ethnic conflicts in the early 1990s. The Somalis who fled to Uganda (via Kenya) after the Somalia civil war of 1991-1992 are approximately 800 in number. Of the remainder, there are 49 Burundians, 53 Sudanese, 40 Ethiopians, 1 Eritrean and, until September 2003, 83 Kenyans (mainly of the Luhya tribe) who fled from the Rift Valley tribal clashes in Kenya. These numbers are according to the official camp statistics from the camp administration.

Refugees are a protected population and refugee camps are protected areas under the joint custodianship of UNHCR and the Ugandan government, specifically the Office of the Prime Minister, represented in the camp by the Camp Commandant. The entry points to provide succour for refugees are varied. The Ugandan government provides basic health care in the form of a staffed health centre in the settlement. The Red Cross supports this service by providing volunteer health workers and an ambulance service, which ensures the transference of emergency cases to Mbarara University hospital. The Ugandan government has also established three primary schools in the settlement, to which all refugee children are entitled free admittance. These schools are staffed by volunteer teachers under the auspices of the Red Cross.

In addition, the Red Cross has constructed and staffed several pre-school centres in various locations in the settlement. UNHCR provides a basic food package of 5 kg of beans, 10 kg of maize meal and 5 litres of cooking oil monthly for each registered refugee household. This the refugees must supplement themselves; mostly by farming the pieces of land that each registered refugee household is allotted. In what is mostly a semi-arid part of the country with a very short rainy season, the refugees can mostly only grow beans, tomatoes, sorghum and groundnuts, as well as raise goats.

Mental health provisions for the refugees have been limited to an occasional visit from the Psychiatric Officer attached to Mbarara University Psychiatric Unit – due to personnel and funding constraints. Given the above conditions, it would appear that a refugee officially registered in Nakivale settlement has the possibility to reconstruct and normalise his or her life, provided he or she remained psychologically healthy despite his or her conflict and flight-related experiences.

The above details are important because it has been argued that low-income post-conflict communities are more in need of basic emergency provisions and support to the social fabric than mental health considerations. Mental health intervention models among such populations have often been considered as a medicalisation of what is essentially a socio-economic consequence of conflict. (Summerfield, 1997; 1999)

This project aims to study whether or not refugees, years after exposure to extremely stressful and traumatic events, and with their basic socio-economic needs met,

would still suffer from mental health disorders requiring intervention.

vivo

vivo is the acronym for *victim's voice*, an NGO that provides psychosocial intervention to traumatised people. A trauma therapy has been developed within *vivo*, referred to as Narrative Exposure Therapy (NET) with the goal of addressing the needs and possibilities for mental health assistance in refugee camps. In a controlled clinical trial, NET has been tested in a controlled field study in North Western Uganda in the Imvepi Refugee Settlement, which is host to Sudanese refugees (Neuner et al., 2004, Schauer et al., 2003a).

It has also been applied in large-scale missions in Somaliland (Odenwald et al., 2002, 2003) and the Northeastern provinces of Sri Lanka (Elbert et al, 2003) as well as in acute situations in a Macedonian refugee camp during the Kosovo crisis (Neuner et al., 2002). Finally, NET is employed as a therapeutic approach to treat torture victims and refugees who seek asylum in Europe, specifically at the Trauma Outpatient Clinic for Refugees jointly run by *vivo* and the University of Konstanz.

The tenets of *vivo*'s operation include a stringent scientific results-based approach to trauma treatment. Apart from bringing together different professionals from a variety of disciplines, *vivo* is also a coalition of institutions undertaking research together. For *vivo*-Uganda this includes the *University of Konstanz* Department of Clinical Psychology and the *Mbarara University Of Science and Technology* Department of Psychology. Current directions in the operations of *vivo* include establishing permanent sustainable treatment projects for traumatised populations in new and present locations.

Narrative Exposure Therapy (NET)

Narrative Exposure Therapy was developed by members of *vivo* as a therapy for disorders of the trauma spectrum. Survivors of violence, armed conflict and forced migration have often been exposed to extremely stressful and traumatic events. They may develop psychopathologies, including Disorders of Traumatic Stress. Key among these is Post Traumatic Stress Disorder (PTSD).

Research into Psychotrauma has already long shown that the most effective (meaning leading to the most significant symptom reduction) therapies for Post Traumatic Stress Disorder (PTSD) include an exposure component (Foa et al., 1999; Foa & Kozak, 1986; Foa et al., 1995; Foa & Meadows, 1997). This means that the patient is exposed in a controlled way to the traumatic experience, usually through imagery and recollection, until the physiological arousal has habituated. In practice, the client is asked to recall the event within a safe therapeutic setting, in the supportive presence of a qualified therapist.

In the 1980s, therapists in Chile developed what is now known as Testimony Therapy (Cienfuegos & Monelli, 1983). Victims of torture in Chile were asked to testify about their experiences and these experiences were documented. It was later observed that those victims who had testified (verbally) about their torture experiences also experienced better psychiatric outcomes than those who did not. Since then, the value of testifying about one's traumatic experiences as a therapeutic procedure has been attested to in other studies (Neuner et al., 2001, 2002, 2004; Lustig et al., 2004; Weine et al., 1998). Testimony giving further allows the trauma survivors to explore more about their identity, not as victims

but, more importantly, as survivors (Igreja et al. 2004).

Narrative Exposure Therapy combines aspects of Testimony Therapy and Exposure Therapy in that patients are helped to re-enter their traumatic experiences while they recount their autobiography to the therapist who documents it. The patient is exposed to the memory of the traumatic events by talking about what happened, and eventually reconstructs a testimony or document of his or her entire life (for details see *vivo*-NET Manual, 2003).

Narrative Exposure Therapy has an additional theoretical grounding. Studies in memory suggest that memory is stored differently for different events (Brown & Kulik, 1977; Ehlers & Clark, 2000). PTSD is therefore a disorder of the memory in that autobiographic memory is interrupted and emotions attached to different events are disarrayed. This disturbance of memory contributes to the reliving that the patient experiences in the form of nightmares or unwanted thoughts or images. The time and spatial realities of the traumatic memory are also inefficiently stored; hence the patient is unable to distance him or herself from past events. Rather, he or she lives in them as a current occurrence, hence the traumatised state.

For these reasons, in Narrative Exposure Therapy, the narrative must be chronologically correct, beginning at birth up to the present, and exploring traumatic events where they belong within the patient's lifeline. This reinforces the temporal and spatial occurrence of events in the past, loosening their current grip on the patient. During successive re-readings of the testimony, the patient is helped by an empathetic therapist to explore all aspects and details of the events and to place them in perspective, as well as to resolve his or her emotions, thoughts and sensations relevant to the events. This is done in an environment that the patient can perceive as psychologically safe; where his or her experiences are unconditionally accepted.

During a small number of sessions, the therapist helps the patient to reconstruct his or her biography and documents it. The patient finally receives this document, which he or she confirms as a correct and complete rendition of the events of his or her life. Experience shows that the repeated retelling and correction of the testimony, as well as successive exploration and resolution of feelings, bodily sensations and images lead to habituation of the anxiety levels which the patient initially feels while being exposed to the traumatic events. This process is the key to symptom reduction.

Among the advantages of NET is its applicability across all cultures since every culture has an oral tradition of sharing experiences. NET is also applicable as a short-term therapy. As few as 4 to 6 sessions per patient have been found to be effective in significantly reducing posttraumatic symptoms (Neuner et al., 2001, Neuner et al., 2004).

In summary, NET has the following characteristics:

- It allows scientific examination of stress related information processing.
- It has an explicit human rights orientation of 'testifying'. Psychotherapy for survivors of human rights violations has often been criticized for neglecting the context of violence and for medicalising the consequences of war.
- Since the testimonies created by the survivors can be used to document human rights violations, the NET procedure helps the person to regain dignity and satisfies the survivor's need for justice. It

also offers an opportunity for advocacy on behalf of one's community and people.
- It is sensitive to the cultural background of the people.
- It can be scientifically validated through controlled studies to evaluate the efficacy of the treatment.

Undoubtedly, there are potentially harmful side effects of talking about traumatic life events. Victims must not be harmed again when they are just about to turn personal pain into therapy or justice. Inappropriate interviewing techniques may hurt the victim by replaying trauma and impairing memory. Therefore, therapists and paramedical personnel must be adequately trained, using appropriate training procedures.

Supportive counselling

Supportive counselling (SC) is one of the most common trauma interventions currently practiced, and is broadly defined by different professionals. As used in this text, it refers to a psychological intervention embedded within the principles of counselling, in which the main focus is not so much on the past trauma, as on support to the client to achieve short-term goals and promote more adequate functioning on the level of ordinary, everyday behaviour (Van der Veer, 1998). A strong problem-solving component is incorporated. This approach is often seen as more relevant to survivors, who need to meet the challenges of post-trauma life, than trauma-focused interventions. Supportive Counselling has among its advantages that:
- It is considered less personnel and time-intensive, therefore adequate for use in high-case-load populations such as war-survivor or refugee populations.
- It can be (and has been) compared to other trauma-treatments in controlled treatment outcome studies.
- It involves a verbal sharing of experiences between (two) people in a trusting relationship and is widely considered culturally acceptable for most populations.

The guiding and also theoretical premise of Supportive Counselling maintains that treatment approaches targeting current adjustment and life-reconstruction challenges are more practical and meaningful than post-trauma focused treatments.

Introduction to the Nakivale camp project: the assessment phase

A mental health project in a place like Nakivale refugee settlement would naturally begin with an assessment phase, which would involve discussions with different key groups in the community. Public meetings were held with official and traditional leaders and select groups of men, women and adolescents – also on an individual basis. This was done, not only as a formal foundation-laying stage for the project, but also as an information exchange phase and for unstructured qualitative data collection.

We also interviewed the camp officials as well as the community leaders and select groups as to whether or not they felt that mental health was a priority in the settlement. The officials could recognise that cases of violence, substance abuse and conflicts in the settlement were directly related to some individuals remaining affected by their conflict-related experiences, in spite of their present life conditions and the duration since the distressing events took place. The leaders of various communities could name individuals within their own communities who, had never quite recovered from the war' and that this constituted a problem

for the affected themselves as well as their families.

It was unanimously agreed that a programme addressing mental health needs would be welcome in the settlement, especially since no such programme had ever been established before. These views were later confirmed by direct requests for treatment from individuals within the settlement and their family members. While the different leaders and key informants (Somali, Rwandan, Government officials) could describe mental disorders only in rough terms, like 'he does not sleep', 'she runs away at night and screams', 'they are poor because he drinks brew', etc, they recognised that negative conflict experiences could leave long-term consequences on the survivors and their immediate environment. It must here be noted that while pre-project assessments and inquiries are important, our experience shows that the clinically ill, partly due to compromised functioning on all fronts, are usually inadequately represented in such discussions. Only a systematic, scientific epidemiological survey can unequivocally establish the incidence and prevalence of mental health disorders, and the consequent treatment needs of such populations. Such a survey would identify those whose own coping and problem solving skills had proved insufficient to lift them out of psychiatric illness resulting from negative life events.

Research in psychotrauma reveals that the majority of PTSD cases remit over time, but a core percentage do not recover without psychiatric help (Saigh et al., 1999). A clinical assessment would be able to identify such persons. Finally, a key symptom of PTSD is avoidance. It is extremely unlikely that patients suffering from PTSD and its comorbid disorders would openly admit to this in a casual appraisal. A personal diagnostic interview would be needed to elicit such information. Such an interview, employing standardised instruments validated in psychiatric practice worldwide and in the specific cultural context, obviates socially desirable responses and interviewer bias both in screening and treatment outcome interviews.

Previous work done by *vivo* has already proved NET to be an effective therapy for PTSD in comparison with other therapies such as Supportive Counselling and Psychoeducation (Neuner et al., 2004). What remained to be seen was NET's disseminability; i.e. could motivated laypeople from within the community with only basic education, as opposed to foreign experts with high levels of special education, be trained to offer effective trauma treatment to fellow (traumatised) community members? In a similar vein, while the place of Supportive Counselling in clinical practice needs no confirmation, could laypeople be trained to acquire adequate counselling skills within a short-term training? The answers to these questions would make meaningful progress in trauma work worldwide. These questions were explored within the framework of the Nakivale camp project.

The goals of the project were:

1. To carry out an epidemiological survey that would gather information about the physical and mental health, nutrition, education and other socio-demographic indicators of the refugee population, as well as the incidence and prevalence of PTSD within the camp. To this end, local people – refugees resident in the camp – were trained as interviewers to collect the epidemiological data – including PTSD-diagnostic information. Experts with an academic training in clinical psychology tested the validity of the diagnoses in a subpopulation.

2. To train local people - refugees resident in the camp - as therapists to conduct treatments with identified patients in both NET and Supportive Counselling. The treatment effects would then be evaluated and validated by experts through a 'blind' process. After a two-month period with extensive supervision, the local therapists would continue to conduct treatments autonomously with reduced supervision.
3. To refine a child-friendly version of NET, for use with traumatised refugee adolescents and children.

The project was approved by the Government of Uganda (as represented by the Uganda National Council of Science and Technology), as well as the Ethical Review boards of the Mbarara University of Science and Technology, Uganda and University of Konstanz, Germany.

Psychological Instruments

It is now a widely accepted fact that epidemiological and treatment outcome research in the field of psycho-trauma depends largely on the efficacy of the diagnostic instruments used.

For this study, the Posttraumatic Diagnostic Survey (PDS) was chosen as the chief diagnostic tool because of its confirmed psychometric properties as a self-report questionnaire (Foa, 1995; Weathers & Keane, 1999). It is the only self-report measure to assess all six (A-F) criteria for PTSD in the DSM-IV. Part 1 of the PDS is a 13-item checklist of potential traumatic events. Part 2 consists of eight items that help determine if an event meets the DSM-IV definition of Criterion A. Part 3 assesses the frequency over the past month of the 17 PTSD symptoms, using a 4-point scale ranging from *0 - Not at all or only one time to 3 – 5 or more times a week / almost always*. Part 4 assesses the impact of symptoms on various aspects of social and occupational functioning. The PDS yields both a dichotomous diagnostic score and a cumulative symptom frequency score. An individual PTSD symptom is counted as present if the corresponding PDS item is endorsed as a 1 or higher.

The Composite International Diagnostic Interview (CIDI) was chosen to support the diagnostic judgement of the local interviewers (WHO, 1997). In the validation, a sample of the respondents to the local interviewers (who used the PDS) was re-interviewed by clinicians using the CIDI section K, within a two-week period.

The Hopkins Symptom Checklist 25 (HSCL-25) was chosen to indicate the possibility of comorbid depression and again the respective CIDI section E was used for validation purposes (Derogatis et al., 1974). A more extensive investigation with other sections of the CIDI would have been impractical given time and personnel constraints.

Recruitment and Training

Interviews in English. The first step in recruitment was to hold interviews in English for all would-be trainees. Proficiency in these tests (which included also an oral interview and a written essay on a chosen topic) would indicate basic literacy as well as English Language skills and an adequate intellectual skill base for further training. Although the trainees would eventually work in their mother tongue, a good command of the English language was a prerequisite as all the training was to be offered in English. These interviews were open to all registered refugees of the Rwandan and Somali communities of permanent residence in Nakivale Settlement regardless of age, gender or religion.

The 24 most proficient interviewees were

selected for training. Of the 24 would-be trainees, 12 would be trained as interviewers, six from each language group, and the remaining 12 as therapists. A further test was needed to assign the trainees into the right groups.

Exercise in NET. As has already been explained, NET as a therapy requires that the therapist documents the patient's story as he or she tells it, and then reads it back to the patient within the session and during subsequent sessions. The therapist must be able to do this while monitoring the patient, and accompanying them back into the autobiographical events, including the emotions vested in each event. This would require good language skills in the working language, such as reading and writing skills, as well as a basic therapeutic disposition, including such elements as empathy.

It was also important that the would-be therapists had a good command of their own mother-tongue, in which they would be working, in addition to English.

Both abilities were judged by an exercise in NET. Each trainee was required to document another's account of a happy event, while he or she wrote it down, all the while monitoring the emotional state of the 'patient' and actively helping him or her to reconstruct the story.

Although the therapist does not write a document during Supportive Counselling sessions, a case summary would be required at the end of treatment, a copy of which would be in the client's mother-tongue. The above skills were therefore also relevant to Supportive Counselling. In addition, basic therapeutic attitudes were tested during counselling exercises.

The six most proficient in each language group were designated as therapists and the rest as interviewers. To begin with, all trainees were trained together, regardless of designation, which then applied after the groups moved on to specialised training in interviewing and therapeutic skills.

General training. All successful interviewees, the best 12 from each language group (Kinyarwanda & Somali), were then given a general training by the expert Clinical Psychology team from the University of Konstanz and *vivo.*

These two full days of training, from 9.00 am in the morning to 5.00 pm in the evening, included an introduction to mental ill-health and its categories, as adjacent to physical ill-health. This led to an emphasis on Post Traumatic Stress Disorder as a specific mental health category, and a discussion of the events that may lead to PTSD, drawing heavily on the experiences of the refugees themselves, such as war and conflict situations.

More time was spent on a discussion of the symptom clusters of PTSD and how these are diagnosed. This led to the introduction of the key instruments to be used in the study: the PDS, HSCL and the CIDI. For the purposes of this study, the CIDI Sections K (PTSD) and E (Depression) were considered relevant. For the first day of training, all 24 trainees were taught together in one big group so as to achieve an initial grounding in the key concepts of PTSD. From the second day, group work format was introduced.

Smaller groups of trainees, still within language groups, worked under the supervision of an expert psychologist to get to know the instruments better. This involved first reading through the instruments, then rehearsing them item by item as one would do in an interview, then taking turns in doing role-play item by item for each instrument until all the trainees thoroughly understood and could recognize the symptom manifestations of PTSD.

Translation. Translation of diagnostic instruments also began from the third day of training. The first part of the project would be a large epidemiological survey, using a 12 page Demographic Interview. The first part of the interview comprised questions to elicit socio-demographic data such as personal characteristics, nutrition patterns, physical health indicators, socio-economic markers such as occupation, as well as substance use information.

The second part of the interview, however, contained a list of possible traumatic events that the subject could have experienced that would contribute to the development of PTSD, compiled from experience from precedent work with traumatised populations. This was followed by the PDS and the HSCL as diagnostic tools to screen for PTSD and Depression. It was based on this diagnostic information that patients would be invited for therapy. It was thus crucial that the interviewers thoroughly understood the concept of PTSD and its diagnosis, as well as applied each item on the PDS and HSCL correctly so as to achieve a correct diagnosis.

More important, these instruments had to be rendered with optimum accuracy in the language of the interviewer and the respondent to obviate all communication bottlenecks inherent in the process of oral transfer of information from one language to another as would have been the case were the instruments to remain in English and each interviewer were to interpret each item as he or she thought best. A standard translation of the PDS, HSCL and CIDI, as well as the Demographic Interview in its entirety was thus mandatory in order to standardise the epidemiological survey in each language.

Translation was done by all the trainees, working in small groups within their mother-tongue groups and as experts in their own language, under the supervision of an expert psychologist. Each group worked on one instrument such as the PDS or HSCL to render it item by item into Kinyarwanda or Somali.

Usually one member of the group was a better translator than the others, but the whole group had to discuss and ratify the final translation of each item as to language usage and accuracy in conveying the concept. When a final translation was agreed upon, it would be given to a different group that had not worked on the translation. This group would work on the vernacular copy to back-translate it into English. The translations and back translations were then compared to check how accurately each item had been translated and then back translated. Less than accurate renditions were discussed again until the final translations were ratified as mirroring the original concept.

Translation was a completely new step for the Kinyarwanda language, into which these instruments had never been rendered before.

The instruments, with the exception of CIDI section E, had been translated into Somali during a previous project in North-Western Somalia (Somaliland), but corrections and refinements were in order to comply with the Somali dialect spoken in Nakivale, given that many of the Somalis were from Southern Somalia. Since the CIDI sections K and E would not be in general use by the interviewers, but rather, would be used by the expert team in validations of the PDS and the local interviewers, it was not translated in the groups, but by our best trainees. It was, however, thoroughly discussed as part of the training and featured in role-play.

Similarly, the general parts of the

Demographic Interview that did not require prior knowledge of PTSD was separately translated by our best translators in each language group, but again, discussed and ratified by all the interviewers in the process of practice and role-play.

Specialised training for interviewers. With the translated instruments ready in Kinyarwanda and Somali, the interviewers could begin specialised training during the second week. This included training in basic interviewing skills, as well as further acquaintance with each item in the entire demographic survey. This necessitated reading each item (from the beginning of the questionnaire) and ascertaining what was meant by the question, what information was expected in response, and where and how to record it.

This was followed by practice sessions in which each interviewer participated, and role-play, in which each interviewer played both the interviewer and the respondent. Again, work was in small groups of up to four within each language group, guided by an expert. After three days of specialised training, particularly in interviewing with the particular instruments to be used, the interviewers were ready to do the first interviews, but under supervision. This meant that the interviewers were accompanied by the expert team, each expert working with one or two interviewers and guiding them as they carried out the interviews. This was done for the next three days, after which the interviewers carried out the interviews with reduced supervision.

The translation of chief diagnostic tools in common use in modern psychiatry into non-western languages was in itself a remarkable philosophical threshold in the field of psychotrauma. It has been argued that PTSD as a concept is entirely Western, and both the concept and its diagnostic instruments could not be accurately rendered into non-Western languages. This has been one of the final frontiers inhibiting research into trauma worldwide. Additionally it was doubtful whether local interviewers, lacking years of higher education and training in psychology, could grasp the core concepts well enough to accurately diagnose PTSD. Here was the moment to find out.

Specialist training for therapists. Meanwhile, the therapists were additionally undergoing a specially tailored training, which started with the theoretical rationale of NET and its development. After an initial day of theoretical training, the trainee therapists then worked in groups, each group supervised by an expert, some of them the originators of NET itself. As part of NET in practice, the experts conducted NET with real sufferers of PTSD, while the trainee therapists acted as interpreters, thus being able to follow the treatment course from session to session. Next, the trainee therapists conducted NET treatment sessions on their own, under the supervision of an expert.

An Individual Training Programme was adopted in which individual therapists were helped by various experts to acquire different skills at their personal pace, since not all the trainees were of the same age, educational background or life experience. In fact, the trainee therapist group showed the most diversity in recruits, from primary school leavers to a university graduate, and from early adulthood to middle-age, from single people to family people. It was therefore imperative to include private tutorials for each trainee in addition to the standard general training. After six weeks of training, the trainee therapists had each reached a stage where they could conduct therapy on their own with traumatised patients from their own community.

It was essential that NET and Supportive Counselling would be comparable on all fronts. As such, equal training duration time was accorded for each therapy type. A similar training protocol was employed in training the therapist group in Supportive Counselling, by the expert counsellor, who runs a renowned counselling training and supervision institution, with trained experts working throughout the country. She introduced the trainees to counselling by giving a general training into the precepts of the method. This included a general theoretical grounding in the concepts key to counselling, such as empathic and congruent attitude, active listening, emotional processing, case analysis, case report writing, problem solving and coping skills.

This was followed by practical sessions under expert supervision, singly and in groups, and group discussions of cases and method. Trainee therapists acted as interpreters for expert therapists, before carrying out counselling on their own, under supervision. Individual training programs were established for both therapy types for trainee therapists who needed special help, and both treatment types were given to trainee therapists who requested it.

Within the treatment study, equal numbers of sessions (4-6) were accorded for both treatment types. While in NET the patient's life story was documented, in Supportive Counselling, his or her day-to-day problems were explored and documented, with a view to problem solving and the build-up of coping skills. All patients received a written document at the end of treatment: whether a chronological life story or a case summary and report.

Finally, trainee therapists were considered well-equipped enough to counsel clients with only semi-monthly group personal and case supervision.

At the end of the therapy/counselling training, the trainees were equipped with two methods for psycho-social treatment: NET, a traumafocused intervention and supportive counselling, a support and coping skills focused method.

Procedure for the epidemiological survey

Two different sampling techniques were chosen to arrive at a representative sample of the about 12,800 members of the target communities. Since the Somali community was fairly small - up to 800 officially registered persons - it was decided to do a complete sample. This eventually added up to 561 interviews. All Somali refugees permanently resident in the camp were interviewed.

The Rwandan community is heterogeneous and do not necessarily share characteristics. Although mostly of Hutu origin, they did not all arrive in Nakivale at the same time. The first group of Hutu Rwandans arrived in 1990, after the first wave of unrest in Rwanda. Their experiences naturally differ from those who arrived in 1994 directly from the genocide, and others who came later, after first fleeing to Tanzania in 1994 and then later fleeing to Uganda to escape forced repatriation. Still others arrived as late as 2001 or 2002, after escaping death threats, imprisonment and torture. The Rwandans are organised in villages according to the time of arrival. The sampling method would have to take into account these differences as well.

To arrive at a representative sample of the Rwandan community of about 12,000 people, a random sampling technique was chosen. Since the Rwandan villages are not of the same size, it was necessary to work out a percentage sample from each village correspondent to its contribution to the whole

Figure 1: This photograph illustrates interviewer Moses Nsamba during a typical situation of an interview carried out during the epidemiological survey. The picture was taken, while the interviewee was asked to perform a memory test.

settlement. Using this number of households to be sampled from each village, the random sampling would begin from the central point of each village (usually a trading centre) and sample households after the calculated interval in each of the four directions outwards, since the villages were spread in no recognizable order.

Procedure for the treatment study

The interviewed subjects were screened for PTSD from their interviews. Those who were affected were invited to participate in the treatment study. A patient list was then constructed, and the patients assigned at random to either of two treatment groups: Narrative Exposure Therapy (NET) or Supportive Counselling (SC) well in advance of treatment. Female and male patients were on different lists, and were assigned alternately to either treatment. The therapists were then assigned blindly to carry out alternate NET and SC treatments of equal numbers. Therapists treated patients of their own sex of varying age, religion and socio-economic background. In general this rule was maintained unless one therapist needed the support of another therapist of the opposite sex, in which case they would conduct therapy together, in agreement with the patient. Both NET and SC were conducted for between 4 and 6 sessions for each client, with each session lasting between 1 and 2 hours; optimally 1 and 1/2 hours (Figure 3). At the end of therapy, patients assigned to NET therapy would receive the documented account of their lives to date, while the clients assigned to SC would receive a case summary, including a problem-solving report of problems or challenges discussed and solutions or coping strategies explored.

As already mentioned, *vivo* as a research coalition follows stringent scientific methodology. In the field of Psychotraumatology, therapy evaluation is mandatory as part of

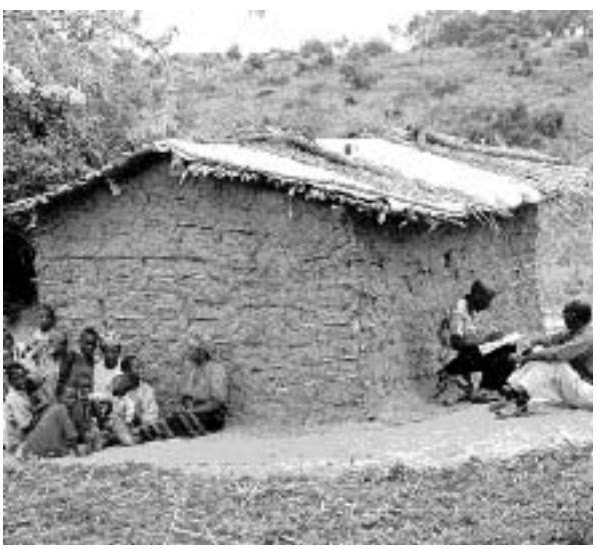

Figure 2: NET-treatment of a patient. Location was by choice either at the refugee's home or at the project centre.

standard practice. This presupposes a pre-treatment assessment with relevant clinical instruments such as the PDS to screen for incidence of PTSD, as well as quantify the magnitude of symptoms.

After whichever treatment is administered, a post-treatment test is carried out after four weeks from the last treatment session to ascertain the effects of treatment, such as change in symptoms, and to quantify the magnitude of these changes. Follow-ups after 3 to 6 months and 1 year are also carried out to the same end. It is only after qualified evaluation that comments about treatment effects seem justified. *vivo* finds it unethical to propagate any treatment type before its effectiveness is proven beyond doubt, hence the precedence of research projects before general treatment programs on a large scale.

The evaluation of the treatment study is currently underway. Over 100 completed treatments, both SC and NET, were post-tested after at least a four-week period from the last treatment session, the six-month follow-up was underway during the write-up of this paper and a one-year follow-up by a team of expert clinicians blind to the treatment type has started in January 2004.

The post-tests and follow-ups involve interviewing the treated patients using the same questionnaire, including the PDS and the HSCL, which were the original diagnostic tools. Employing the same tools for evaluation effectively assesses the occurrence and magnitude of any treatment effects, such as symptom reduction or restored functioning. The evaluators – local trained interviewers – are blind to what treatment each patient received, and this eliminates interviewer bias.

Preliminary results already show significant symptom reduction and a return to function in important numbers of patients treated with both NET and SC. As these evaluations are still ongoing, the comprehensive results will have to be reported elsewhere.

Challenges

It was a challenge to find refugees resident in the settlement with even basic education. Many had had their schooling interrupted by the conflicts from which they fled, and most of those with some education had already left the settlement in search of employment opportunities. We therefore selected the best trainees available and made up for educational deficiencies with thorough training, prolonged supervision and individual training programs.

More important, it was a challenge to find trainees who were not themselves traumatised. It goes without saying that a traumatised individual would be in no position to facilitate the trauma resolution of another. Seven of our therapists had to undergo some form of treatment before they could undertake training.

Translations of the diagnostic tools had to be revised several times before acceptable versions were arrived at. This was a crucial step because treatment would depend on diagnostic information elicited. Incorrect diagnoses would lead to wrong treatment indications.Strict supervision of both therapists and interviewers had to be maintained to ensure correct performance. Supervision was later reduced to allow trainees to develop working autonomy, but only after evidence that performance levels would be maintained. Even then, a thorough monitoring and supervision structure still remained in place.

Discussion

The *epidemiological survey* revealed a high prevalence of traumatisation, with 47% PTSD in the Somali community and 31.1%

PTSD in the Rwandan community. The eventual sample size was 10.23% of the entire camp population (n = 1473: n = 561 Somalis and n = 912 Rwandan).

This study also proved that local interviewers with only basic skills, could, through a high level of training, obtain highly accurate data, and even correctly diagnose a major mental health disorder. In 80% of cases, the local interviewers arrived at the same diagnosis for PTSD using the PDS, as did the expert psychologists who validated the same interviews using the CIDI. This is a respectable validation and confirms that the local-language translations of the clinical instruments could be relied upon for accurate diagnoses - an innovative finding.

The *treatment study* revealed that NET could be taught to refugees with only basic skills, over a short period of time, and that the trainees could equally acquire basic counselling skills even without the benefit of a specialized education. They in turn were able to treat fellow clinically traumatised refugees over a short term (4-6 sessions of no more than 2 hours each.)

After six to eight weeks of training, the local therapists were able to work autonomously for six months (May-October 2003) with only twice-monthly supervision, in which time they completed over 150 treatments.

Each therapist spent more than 150 hours conducting treatments in both NET and Supportive Counselling with over 25 different patients. This structure proved to be self-propelling and sustainable and was only concluded because the treatment outcomes must be evaluated before an even larger scale implementation of any of the treatment forms can be ethically justified.

Since each therapist was reimbursed the equivalent of 90 euros every four weeks and treated an average of 5 patients every four weeks (4-6 patients each) for between 4-6 sessions of up to two hours each, each treatment course was at a cost of 18 euros. While this figure was not of our choosing but was as a result of our inelastic budget, it still goes to prove what inexpensive effective trauma treatment could mean for millions of traumatised people earth-wide, especially in resource-challenged areas like Africa. Long-term, expensive, personnel-intensive and highly specialized trauma treatments, however effective, can simply not begin to address the magnitude of the crisis.

Whereas the effectiveness of NET as a therapy for PTSD, in comparison with other therapies such as Psychoeducation and Supportive Counselling, had been proven before (Neuner et al., 2004), the present observations are landmark findings, in that in this case, local therapists - all of them refugees resident in the camp - and in the main possessing the most basic literacy skills, have been trained to give therapy to fellow clinically traumatised refugees. Given the rate of increase of traumatic events worldwide, and therefore the rate of increase of PTSD, this study can give practical and scientific recommendations to the conceptualisation and implementation of future treatment interventions. The search for a short-term, cost-effective and easily disseminable therapy for PTSD, with a clear human rights orientation is a humanitarian priority.

We have to wait for the outcome of the one-year follow-up to quantify the success rate of each treatment module. However, this study has already demonstrated the feasibility of approaches that rely on the building of local competency for psychological assistance to traumatised refugees, and has detailed how this can be done practically. Not the least of the benefits that accrue for such local populations is the psychological transition from being merely survivors and

victims of circumstances to becoming agents of change within their own communities.

Like any other community, poor African populations deserve programmes of psychiatric intervention based on sound evidence of effectiveness and feasibility, proven in their own cultural settings (Igreja et al., 2004). This paper aims to demonstrate that effective mental health models that build local capacity in order to assist traumatised patients in low-income countries are feasible.

References

Brown, R., & Kulik,J. (1977) Flashbulb memories. *Cognition*, 5, 77-99.

Cienfuegos, J., & Monelli, C. (1983) The testimony of political repression as a therapeutic instrument. *American Journal of Orthopsychiatry*, 53, 43-51.

Davidson, J.R.T., Smith, R.D., & Kudler, H.S. (1989) Validity and reliability of the DSM-III criteria for post-traumatic stress disorder: Experience with a structured interview. *Journal of Nervous and Mental Disease*,177, 336-341.

De Jong, J. T., Komproe, I. H., Van Ommeren, M., El Masri, M., Araya, M., Khaled, N., et al. (2001). Lifetime events and posttraumatic stress disorder in 4 post-conflict settings. *Jama, 286*, 555-562.

Derogatis, L. R., Lipman,R. S., Rickels, K., Uhlenhuth, E. H. & Covi, L. (1974) The Hopkins Symptom Checklist (HSCL) : A Self-Report Symptom Inventory. *Behavioral Science,* 19,1-15.

Ehlers, A. & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy,* 38, 319-345.

Elbert T., Schauer M. (2002) Psychological trauma: Burnt into memory. *Nature,* 419, 883.

Elbert, T., Schauer E., Huschka, B., Schauer, M., Hirth, M., Somasundaram, D. (2003) *Epidemiological survey on children's mental health in the Vanni region (North-Eastern Sri Lanka)*. (Unpublished manuscript) Konstanz: *vivo* mission report. Vanni Region/Vavuniya/Jaffna: GTZ and Ministry of Health, Sri Lanka.

Foa, E.B. (1995) *Posttraumatic Stress Diagnostic Scale* Minneapolis, MN: National Computer Systems.

Foa, E.B., & Kozak, M.J. (1986) Emotional Processing of fear : Exposure to corrective information. *Psychological Bulletin,* 99, 20-35.

Foa, E.B., & Meadows, E. A. (1997) Psychological treatments for posttraumatic stress disorder. *Annual Review of Psychology,* 48, 449-480.

Foa, E.B., Dancu,C.V., Hembree, E.A., Jaycox, L.H., Meadows, E.A., & Street, G.P. (1999) A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology*, 67, 194-200.

Igreja, V., Kleijn, W.C., Schreuder, B.J.N., Dijk, J.A., Verschuur, M. (2004) Testimony method to ameliorate post-traumatic stress symptoms: Community-based intervention study with Mozambican civil war survivors. *British Journal of Psychiatry,* 184, 251-257

Karunakara, U., Neuner, F., Schauer, M., Singh, K., Hill, K., Elbert, T., Burnham G. (2004) Traumatic Events and Symptoms of Post-traumatic Stress Disorder amongst Sudanese nationals, refugees and Ugandan nationals in the West Nile. *African Health Sciences*, in press

Lustig, S.L., Weine, S.M., Saxe, G.N., & Beardslee, W.R. (2004) Testimonial Psychotherapy for Adolescent Refugees: A Case Series. *Journal of Transcultural Psychiatry*, in press

McNally, R.J. (2003) Progress and controversy in the study of posttraumatic stress disorder. *Annual Review of Psychology* 54, 229–252

Mollica, R. F., Donelan, K., Tor, S., Lavelle, J., Elias, C., Frankel, M., et al. (1993). The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps. *Jama, 270*, 581-586.

Mollica, R. F., McInnes, K., Sarajlic, N., Lavelle, J., Sarajlic, I., & Massagli, M. P. (1999). Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia [see comments]. *Jama, 282*, 433-439.

Neuner, F., Schauer, M., & Elbert, T. (2001) Testimony-Therapie als Psychotherapie für Überlebende staatlicher Gewalt (translation of title: 'testimony-therapy for survivors of state-supported violence'). *Zeitschrift für Politische Psychologie*, 9, 585-600.

Neuner, F., Schauer, M., Elbert, T., & Roth, W. T. (2002) A Narrative Exposure Treatment as intervention in a Macedonia's refugee camp: a case report. *Journal of Behavioural and Cognitive Psychotherapy,* 30, 205-209.

Neuner, F., Schauer, M., Karunakara, U., Klaschik, C., & Elbert, T. (2004) A Comparison of Narrative Exposure Therapy, Supportive Counseling and Psychoeducation for Treating Posttraumatic Stress Disorder in an African Refugee Settlement. *Journal of Consulting and Clinical Psychology,* (in press).

Odenwald, M., Schauer, M., Lingenfelder, B. & Elbert, T. (2002) *Report of the vivo mission within the EC/GTZ Demobilization and Reintegration Program Somaliland. (Unpublished manuscript)*. Nairobi: GTZ/Vivo 2002.

Odenwald, M., Schauer, M., Neuner, F. et al. (2003) *War-trauma, Khat Abuse and Psychosis: Mental Health in the Demobilization and Reintegration Program Somaliland. (Unpublished manuscript)*. Cupramontana: Vivo.

Saigh, P.A., Yasik, A. E., Sack, W.H. & Koplewicz, H. S. (1999) Child and adolescent posttraumatic stress disorder. In: Saigh, P.A. & Bremner, J. D. (Eds), *Posttraumatic Stress Disorder.* Needham Heights: Allyn & Bacon.

Schauer M., Neuner F., Elbert T. (2003a) Erzähl um Dein Leben – Traumatherapie bei Opfern von Gewalt und Terror in Krisenregionen (translation: 'talk about your life– traumatherapy for victims of violence and terror in crisis regions'). *Gehirn und Geist, Spektrum der Wissenschaften,* 5, 34-38.

Schauer, M., Neuner, F., Karunakara, U., Klaschik, C., Robert, C., Elbert, T. (2003b) PTSD and the "building block" effect of psychological trauma among West Nile Africans. *ESTSS (European Society for Traumatic Stress Studies) Bulletin*,10, 5-6.

Somasundaram, D. J., & Sivayokan, S. (1994). War trauma in a civilian population. *British Journal of Psychiatry, 165*, 524-527.

Spitzer, R.L., Williams, J. B. W., Gibbon, M., & First, M. B. (1990) Structured Clinical Interview for DSM-III-R. Washington, DC: *American Psychiatric Press.*

Summerfield, D. (1997) Legacy of war: beyond "trauma" to the social fabric. *The Lancet*, 349, 1568.

Summerfield, D. (1999) A critique of seven

assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine*, 48,1449-1462.

Summerfield, D. (2001) The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *British Medical Journal,* 322, 95-99

United States Committee for Refugees. (2003) World Refugee Survey: Worldwide Statistics and Country Reports. Retrieved 12 December, 2003, from http://www.refugees.org/-WRS2003.cfm.htm

Van der Veer, G. (1998). *Counselling and Therapy with Refugees and Victims of Trauma.* (2nd ed.) West Sussex: John Wiley & Sons Ltd.

vivo (2003) *Training Manual for Narrative Exposure Therapy (NET): A short-term intervention for the treatment of Traumatic Stress Disorders in Children & Adults. (Unpublished manuscript)*. Cupramontana, Konstanz, Mbarara: vivo 2003

Weathers, F.W. & Keane, T.M. (1999) Psychological Assessment of Traumatized Adults. In Saigh, P.A. & Bremner, J.D. (Eds.) *Posttraumatic Stress Disorder: A Comprehensive Text.*(pp. 219-247). Needham Heights: Allyn & Bacon.

Weine, S., Kulenovic, A., Pavkovic, I. et al. (1998) Testimony psychotherapy in Bosnian refugees: a pilot Study. *American Journal of Psychiatry*, 155, 1720-1726.

WHO. (1997*) Composite International Diagnostic Interview (CIDI)*. Geneva: World Health Organization.

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[2] For a short summary on Post Traumatic Stress Disorder, e.g., Elbert & Schauer, 2002, for an overview McNally, 2003

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