

Appraisal of psychosocial interventions in Liberia

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This article presents the methodology and results of a study on the effectiveness of two psychosocial interventions targeting female victims of war-related and sexual violence in Liberia. One intervention provided counselling, the other offered support groups and skill training. Qualitative research suggests that the participants of both interventions were positive with regard to the help provided. Quantitative analyses revealed that counselling was effective in reducing trauma symptoms as compared to the support and skill training and to a waiting list control group. Taking into account the number of women with a high post traumatic stress disorder score, both interventions were effective compared to the control group.

Keywords: field research, counselling, sexual violence, Liberia

Introduction

The violence in Liberia began in the 1980s and since that time has increased. Beginning in 1990, the country has survived several periods of extreme internal violence, most recently in the period of 2002–2003. In 2003, the former dictator Charles Taylor was forced to leave the country and was given asylum in Nigeria. Elections were held almost two years later on the October 11, 2005. The elections were considered a success, due to the high level of participation (>60% of the voters), its peaceful manner and the relative transparency of the process. Since January 2006 a new government with the title National Unity was formed, with Ellen

Johnson Sirleaf as president (the first female president elected in Africa). The focus of the new government is to promote reconciliation, national unity and inclusiveness. The years of civil war had ruined the economy of the country and infrastructures have been destroyed. This has resulted in non-functioning basic services (health, education, water, etc.), massive illiteracy (>85% of the population), massive unemployment (>85% of the population) and low life expectancy. Former agricultural activities, both cash crops (rubber, palm-oil, coffee and cocoa), as well as food crops (rice, cassava, grains, beans, plantains, etc.), have had a serious setback or have been completely abandoned, creating malnourishment and lack of export income. The international ban on timber and diamonds limits the export and economic possibilities of the country. In general, the state is absent, services are non-functioning and what is working is provided by non-governmental organizations (national and international), churches and faith-related organizations, or organizations of the UN family (United Nations Missions in Liberia (UNML), United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF)). The majority of the population is very poor, having been robbed of their essential possessions and often have no resources left. Families have been disrupted and the men have often been either killed, or have fled, and therefore absent. As a result, a large number of families are now female-headed households, where women

are responsible for income, survival, health and education.

Conflict and sexual violence

Most African armed conflicts in the recent past are characterized by a very high level of sexual violence (African Rights, 1997). Liberia is no exception. From 1990 onward rape and sexual violence have become increasingly common. Recently cases of sexual abuse of minor children (as young as 18 months) have been documented by women's organizations in an attempt to bring these cases to court. Most informants state that sexual violence existed before the war, but it was limited and dealt with by traditional methods within communities. For example, marriage after rape between rapist and victim was sometimes accepted in order to limit social damage and to ensure a 'future' for the victim. Since the beginning of the war (1990) the phenomenon of rape has expanded extensively. Several rebel movements, as well as governmental fractions, have been involved in sexual violence and kidnapping of women and girls for sexual services. During discussions with women in different villages, they told us that women and girls were victims of sexual violence on a large scale, whether they stayed in the villages or fled to the IDP (internally displaced persons) camps. UNDP reports that 50–60% of the entire Liberian population (women, children and men) have been victims of sexual violence, ranging from rape, gang rape and sexual slavery to sexual mutilation and torture. In numerous cases, this has been accompanied by witnessing the killing of family members and other atrocities (like being forced to bury their own children alive and the cooking and eating of body organs of family members). Almost everyone experienced or witnessed atrocities during the war (UNDP, 2004).

Apparently, the forms and intensity of sexual violence in Liberia differ from region to region. In some areas, women and girls were (gang)raped in public in front of family and community members; in other areas rape took place in more 'private' and isolated conditions. In a country where rape is traditionally considered as a provocation by the woman and not as a crime of the man, these differing circumstances can also create differences in the reactions within the social environment. In some communities, where massive, public rape took place, general embarrassment seems to take the upper hand, but it allows the possibility of discussing rape in a public environment. In other communities, victims of sexual violence keep their history secret in order to avoid social stigmatization, isolation and/or exclusion. In these communities, rape is difficult to discuss in a public arena.

Although most informants state that sexual violence has diminished since the end of the war and the demobilization of the armed forces in the country, several cases of rape, notably of children, have been documented and reported by women's groups and human rights organizations. Adult women often refuse to be identified as victims of sexual violence, because of fear of stigmatization. However, sexual abuse of minor girls is both socially and traditionally unacceptable. In these cases, everyone agrees that social barriers have been trespassed and that the perpetrators should be brought to court. The Association of Female Lawyers of Liberia (AFELL) has brought more than 20 of these cases to court since the beginning of 2005. However, as of now, no single judgement against a rapist has been brought.

From these statements, it can be concluded that a large number of women and girls in Liberia, from all classes, tribes and ages, have

experienced sexual violence in one form or another.

Psychosocial care and trauma healing in Liberia

Until the beginning of 2006 the Ministry of Health had hardly any budget or personnel to carry out any form of health care programme. Therefore, mental health care was not a priority.

Currently, there is only one male psychiatrist and one male clinical psychologist in Liberia. Both run a private practice in mental health care, so these services are only accessible to a small elite. Occasionally, they render services to other organizations in assisting them in the diagnosis of patients. However, both contribute to the development of programmes in specific areas of mental health care and participate in discussions and committees, trying to improve policies in this field. Many non-governmental organizations (NGOs) and actors are involved in the delivery of psychosocial care in Liberia. They each have their own (trauma) counselling programmes and methods. A working group, formed by representatives of these actors (the Mental Health Interagency Coordination Group) is mandated by the Ministry of Health and the Ministry of Education to investigate the need for further training and development of mental health staff, training programmes, and formal professional qualifications. Hopefully, this will lead to the clarification of tasks, roles and professional education of mental health staff, as well as a coherent training programme.

The CCC: trauma counselling within a community-based approach. One NGO, the Concerned Christian Community (CCC) is a church-based organization with different groups involved. It was established in 1990 and started with women from different churches providing counselling. The main focus of

the organization is on psychosocial services and agriculture, with additional services in other fields. The organization uses a community-based approach. At present, CCC works primarily in communities where people have returned from the IDP camps. In total, 15 counsellors provide counselling services in three different sites that cover seven different villages. The teams consist of three to four people and medical personnel (physician assistants or nurses) working alongside trained counsellors in the villages. They take care of a number of previously chosen villages, and visit each village weekly. The team members live in one of the surrounding villages, but are not a part of the community as such. A physician assistant and a counsellor/social worker of CCC supervise the programme weekly. This supervision consists of reading the records of the clients and discussions with medical and counselling staff. The medical and counselling services are free of charge. After the counselling trajectory, some of the clients are recommended for skill-based training. CCC also delivers other services in most villages, such as the construction of a water pump, latrines and the building of a *palava-hut* (a small traditional building where people can discuss their problems).

According to the counsellors, the aim of the psychosocial programme is to help the clients to reduce stress and trauma. At the start of the programme, the population of the villages were sensitized about the counselling programme. The selection of the first clients was based on their story (physical or sexual abuse) and psychological condition, although the criteria used to determine psychological condition are not very clear. There are no contra-indications for joining the programme. The duration of the programme is 3 months, and includes both individual and group counselling. The individual

counselling consists of eight sessions. In the first sessions, an extensive intake is carried out, which includes: statement of the problem, social history pre-war, family history, and a mental status exam. This exam includes the following categories: mood, affect, contact, speech, behaviour and vegetative signs. Clients are also encouraged to tell the entire story about what happened to them during the war. Based on the results of the intake, a treatment plan is developed. In sessions four to seven, follow-up takes place. Session eight is the final session. If required, clients can have additional counselling sessions. The counsellor bases this judgement on the psychological condition of the client and what she has reported about her wellbeing. Counsellors also decide if the client may join the skills-training programme after counselling. A graduation ceremony takes place at the end of the counselling sessions. In addition to individual counselling, group counselling also takes place. Issues covered during these group sessions include: stress management, conflict resolution, hygiene and peace building.

WHDP: support groups and skills training. The Women's Health and Development Program (WHDP), supported by an American consultant, started in 1994 as a result of an analysis of the level of violence against women. This survey showed that many Liberian women had experienced violence, but at the same time were unable to talk about sexual violence they had experienced, and its consequences. Excellent training materials were developed by WHDP, based on traditional stories, to promote and encourage discussion of violence and sexual abuse. Midwives and traditional attendees at births were trained to use these materials within women's groups.

However, since 2002, the programme has altered its approach. The main focus is now

on skill training for income generating activities, like tie-dyeing fabrics, sowing and soap making.

The women's groups also discuss gender issues and sexual abuse. Sadly, it is not possible to use the training materials mentioned above in these discussions as they were all looted during the war. Although there are no direct counselling aspects in this programme, indirectly the programme can reinforce coping skills, notably through reduced risks and stressors and by increasing protective factors.

Methodology of the study

For the study¹ both qualitative and quantitative methods were used. Qualitative research was conducted at the organizational level, as well as at the level of the target group. At the organizational level semi-structured interviews were held with directors and staff of the two aforementioned organizations; counsellors, representatives of NGOs (both international and Liberian) who focus on psychosocial, juridical and human rights programmes; state government staff; and the consulting psychologist and psychiatrist (resource persons). In addition, counsellors were observed during their work with the clients. Within the target group, individual interviews were held with women participating in any one of the interventions of either organization. Also, focus group discussions were held with women participating in the interventions. Two of the authors of this article carried out all of the interviews referred to above. A female Liberian researcher carried out further individual interviews with the women.

With regard to the quantitative research, a waiting list control group design was used. All participants were Liberian women who were victims of sexual violence during the war. They were approached and interviewed

through select sampling. The first group received trauma counselling through the CCC. The second group received the intervention of WHDP. The waiting list control group was formed of women who wanted an intervention from either one of the two organizations. Because the counsellors could not help all the women concurrently, these women were assigned to a waiting list. The waiting list control group consisted of women pre-selected to receive the assistance of the CCC or WHDP.

The pre-test was performed before the groups had participated in any of the interventions (pre-intervention measurement). Questions were related to trauma events, with a focus on sexual and physical violence, and on trauma-related symptoms. The post-test was carried out at the moment the groups had finished the interventions (post-intervention measurement). The post measurement consisted of questions concerning trauma-related symptoms.

Instruments. Using an adapted version of the Harvard Trauma Questionnaire (HTQ) (Kleijn & Mook, 1999, Mollica, 1992) traumatic experiences and post traumatic symptomatology of the respondents were assessed. The HTQ is a self-report instrument that has been applied in cross-cultural settings. For this research, the HTQ was adapted in order to focus on sexual and physical violence. In total, nine questions were included about sexual and physical violence. There are four answer categories: (i) experienced; (ii) witnessed; (iii) heard about; (iv) none. The part of the HTQ that measures trauma-related symptoms was not adapted; the first 16 items are derived from the Diagnostic and Statistical Manual-IV (DSM-IV) criteria for post traumatic stress disorder (PTSD). There are four answer categories ranging from 'not at all' (score = 1) to 'extreme' (score = 4). The HTQ end score is

the total of all scores of items 1–16, divided by 16. The cut-off score is 2.5. A PTSD total score of >2.5 is generally considered 'checklist positive' for PTSD (Kleijn & Mook, 1999). This means that the respondent's score of >2.5 is comparable to the scores of refugee patients at a psychiatric clinic who have been given the clinical diagnosis of PTSD.

Procedure. A Liberian researcher, who is independent of both of the organizations, conducted the pre- and post measurements. She received an extensive introduction with regard to the research and ethical procedure by the International Communications Consultancy Organization (ICCO) country representative as well as by a Dutch researcher. In Liberia, the public health adviser of Oxfam gave the Liberian researcher additional advice. The Liberian researcher administered the questionnaire orally to each individual. The qualitative research was carried out during the post measurement by the two authors of this article.

Statistical analysis. To assess whether there is a change in trauma-related symptoms as a result of the interventions the General Linear Model (a method for statistical analysis) with repeated measures was used. The within-the-subject variable was time (pre-intervention versus post intervention) and the between-the-subject variable was group (each intervention and the control).

Results

The pre-measurement. Unfortunately some of the questionnaires could not be used, as they were not completed. In total, 145 questionnaires were analysed. The control group consisted of 21 CCC and 12 WHDP-assigned women. Unfortunately, during the post measurement we were not able to trace the women of WHDP for practical reasons. This means that the complete control group consisted only of CCC women. In this article

Table 1. Number and percentage of women exposed to sexual and physical violence of each group

	CCC	WHDP	CCC control	Total
Number of respondents pre-measurement	58	54	21	145
Number of respondents post measurement	34	22	10	66
Age, mean (<i>SD</i>)	33 (13.0)	34 (11.1)	50 (13.9)	36 (13.6)
Confronted with sexual violence	45 (78%)	28 (52%)	19 (91%)	99 (68%)
Victim of rape	16 (28%)	9 (17%)	3 (14%)	28 (19%)
Physical violence experienced	36 (62%)	14 (26%)	18 (86%)	68 (47%)
PTSD-score >2.5 (pre-measurement)	40 (69%)	8 (15%)	3 (14%)	51 (35%)

CCC, Concerned Christian Community; PTSD, post traumatic stress disorder; WHDP, Women's Health and Development Program.

this is further referred to as CCC control group.

Table 1 shows the percentage of women exposed to sexual violence. In total, 68% of the interviewed women reported exposure to sexual violence. At least once, 47% of the women reported experiencing physical torture. In terms of rape, 19% of the women reported being raped at least once, with 11% reporting gang rape. These percentages may be higher, due to the previously discussed feelings of shame and fear of stigmatization. Furthermore, the percentage of women with signs of PTSD was also very high within CCC. This high percentage is not surprising within the CCC group, because they also experienced high levels of violence.

*The post measurement.*² Table 2 gives an overview of the means and standard deviations of the PTSD score on the pre- and post measurement.

Table 2 shows that the three groups differ with respect to the increase or decrease in scores on the pre- and post measurements.

The CCC intervention resulted in a decrease in trauma-related symptoms compared to the waiting list control group.

The number of women with a PTSD score higher than 2.5 was different between the groups (see Table 1), we examined the effect of this difference. In an additional analysis the number of women with a PTSD score > 2.5 was taken into account. The results showed that for women with a high PTSD

Table 2 Mean and standard deviation of PTSD scores of pre- and post measurement for each group and main and interaction effect

	CCC (N = 34)	WHDP (N = 22)	CCC-control (N = 10)
PTSD score pre-measurement	2.6 (0.87)	1.5 (0.79)	2.0 (0.93)
PTSD score post measurement	2.0 (0.53)	1.7 (0.37)	2.5 (0.56)

CCC, Concerned Christian Community; PTSD, post traumatic stress disorder; WHDP, Women's Health and Development Program.

score, both interventions resulted in a reduction of complaints compared to the control group. So the WHDP programme of support groups and skill training results in a reduction of the PTSD symptoms, but only for women with a high PTSD score.

The results can be summarized as follows.

- There was a difference between the groups with regard to a high score (> 2.5) on the HTQ. The CCC group had a high PTSD score, whereas the PTSD score of the WHDP group and the CCC control group were similar.
- After the intervention there was a *decrease* of the score on the HTQ for women in the CCC intervention.
- After the intervention, there was an *increase* of the PTSD score on the HTQ for the women of WHDP.
- When we took into account the number of women with a high score on the HTQ (the number of women with a high score was included as a covariate) there was a *decrease* of the score on the HTQ for the women of both interventions.
- For the women of the CCC control group who did not receive any intervention there was also an *increase* of the PTSD score on the HTQ score.

Results of the qualitative research

The qualitative research revealed that the counsellors of the two organizations had theoretical knowledge with regard to basic communication skills such as listening and asking questions and non-verbal communication. In practice, it seemed difficult for the counsellors to listen with an open attitude to the clients and to work in a participatory manner.

The counsellors of CCC carry out an intake, whereby the client gives her history in regard to sexual violence. The intake is extensive, and also includes family history, social circumstances and problems. The main problem after this intake is that the counsellors do not have a clear idea what kinds of intervention can be carried out, and in what way. Some of the counsellors advise clients to forget what happened to them and not to blame themselves. This diminishes the experience of the client and is not particularly helpful. Therefore, we may conclude that these CCC counsellors may not be able to provide professionally warranted counselling and are restricted to the level of 'good neighbours advice'. In addition, the counsellors are often very young and sexually traumatized themselves. Some of the counsellors had not yet overcome their own trauma-related problems and that made it difficult for them to help others. It became clear that none of the counsellors had followed any specific training with a focus on sexual violence and sexuality. In the training, no attention was paid to the traumas the participants went through and that it was important to overcome these problems as a prelude to helping others.

The counsellors of the Women Health and Development Program do not carry out an intake. During the group meetings of the social support groups we observed that there was little space in the group for the women to express what had happened to them. It also became clear that few women participated in the discussions.

Yet, the participants of the two interventions were all positive with regard to the intervention. Clients of the trauma counselling intervention of CCC explain that they can now deal with the trauma better, but they still have many socio-economic problems that were not solved. According to the women,

these socio-economic problems result in a lot of stress.

Discussion

The results of the study indicate clearly that the trauma counselling intervention of CCC resulted in a reduction of post traumatic stress symptoms compared to a waiting list control group. The intervention of WHDP was only effective with regard to PTSD symptoms for women with a PTSD score higher than 2.5. As all our research groups were relatively small, further research with larger groups of women showing both high and low PTSD scores is recommended.

The qualitative research suggested that women of both interventions were positive regarding the help provided. However, the women of the CCC trauma counselling intervention said that their socio-economic problems were still persistent and resulted in stress. We also observed that the counsellors of CCC had a lack of knowledge about problems related to sexuality. They had received inappropriate training, ignoring their own traumatization. Some of the counsellors reported severe symptoms of stress.

In the intervention by WHDP, there was little openness in regard to sexual violence. As a result, women were unable to give each other social support in regard to these issues.

It is interesting to see that the two interventions, both far from perfect, and carried out by counsellors who were not adequately trained, still resulted in some symptom reduction.

We believe it is important that women can express their experiences, problems and solutions in a safe environment, especially in regard to sexual and war-related traumas. We also believe that a well-trained counsellor can play a positive role in assisting

these women (either individually or in groups) in coping with these problems. This was more or less the case for the women of CCC.

However, such an intervention is not sufficient in a country where socio-economic problems are still persistent and women struggle to survive. Therefore the WHDP intervention where women learn to set up income-generating activities is important as well. Creating employment possibilities, or promoting economic and income generating activities, can contribute to reinforcing hope, distract the mind and reorient them to survival and reconstruction of their lives. Furthermore, economic and income-generating activities can have a positive impact on the self-esteem of the women.

It might be possible that a combination of these interventions would have better results. It is essential that victims of sexual violence have the opportunity to talk openly about their problems. However, this is not enough on its own. Trauma counselling and socio-economic programmes should go hand in hand and will hopefully reinforce each other in dealing with traumatic experiences in a better way.

Further research on such a combination strategy is therefore recommended.

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² One important constraint was that all the organizations were not sufficiently informed or had clarified the aim and procedures of the research. The concept of *control group* was also not thoroughly understood. Moreover, in Liberia many women have the same name and do not know their precise age. This was therefore

problematic in finding the women again for the post measurement.

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