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Sensitization around psychological trauma: the results of a campaign in a district of the Democratic Republic of Congo

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In the north eastern part of the Democratic Republic of Congo (DRC), an area affected by war and armed conflicts, a sensitization campaign about (coping with) traumatic stress has been carried out. This campaign has positively influenced the awareness of key community members to traumatic stress. In this paper, the campaign and its results are presented.

Keywords: Democratic Republic Congo, sensitization, traumatic stress, armed conflict

Introduction

Ituri is a district in the north eastern part of the Democratic Republic of Congo (DRC), along the Lake Albert, and is close to the border of neighbouring Uganda. In 1999, a war, fuelled by regional powers, broke out in Ituri. Since then, the area has been the site of an extremely bloody ethnic conflict. While the war is officially over, violence against the population and political insecurity remains, despite the peacekeeping efforts of the UN Mission and the international community. The centre of Bunia (the main town in Ituri) is secure, but outside this centre the region is still controlled by violent armed groups.

Since the nineties, Medair, an international humanitarian organization, has been running a medical programme in Ituri to increase the accessibility of health care. After the resurgence of extreme atrocities in 2002–2004 in the Irumu-area (part of Ituri), Medair also began a psychosocial programme to reduce the effects of war related post traumatic stress among the population of Ituri. During the first two years, the psychosocial programme's main focus was to train and supervise key members of communities in counselling skills. In the beginning of 2006, a sensitization campaign about traumatic stress and self-help techniques were started within the programme. In this paper, we explain why Medair started this campaign and present some of the initial findings.

Starting a sensitization campaign

After two years of training counsellors, from January 2004 to December 2005, there were three main reasons for starting a sensitization campaign instead of only continuing with the training of new groups of counsellors:

1) Medair's psychosocial team (which included three Congolese psychologists, a Congolese logistician and secretary and one expatriate psychologist/manager) discovered a lot of false beliefs and misunderstandings about traumatic stress. The counsellors

(trained by Medair in a former project phase) met a lot of people who could be helped just with information about their psychological reactions to stress and who did not require further counselling. Knowledge about traumatic stress and the way to deal with it has been very limited among the population of Ituri. For example, a lot of people consider nightmares as a symptom of being possessed by the devil, or of being completely mad. Neither diagnoses is advantageous for participation, nor reintegration into communities.

2) By applying the Sphere guidelines (which evaluate the quality of projects), the question was discussed if the guideline that *all people should have access to health information which allows them to protect and promote their own health and wellbeing* (chapter 5, standard 4)[1] is applicable to psychosocial programmes. We decided to apply this guideline to this type of programme and to prioritize this guideline instead of continuing with the training of counsellors. Medair expected that giving information about traumatic stress and mental health could be the first step towards the development of mental health care in a war-torn area (which could be a positive side effect of the intervention).

3) We expected that receiving information would have a positive effect in taking an active role in restoring one's own wellbeing. Medair knew that the problems of a lot of survivors were so serious that they could not be resolved with general advice. Medair also knew that some survivors were suffering from such severe depression and shock that they would be unable to take an active role in their own process of healing. However, by giving the general population information about what was going on in their minds, and by giving them the tools to take some responsibility in this healing process, Medair hoped that a large part of the reached population could acquire some renewed control of their lives. It was the feeling of control that they had lost due to traumatic events. Instead of being passive and waiting for help, they could then actively take part in their own healing.

Method

In the pilot phase, the information sessions had around 4200 participants. Most of them were key members of communities in the Ituri area (pastors, teachers and staff of health centres). There was also a special focus on young people and therefore, in some areas, Medair visited schools. At secondary schools, apart from a session for teachers, a session for the students was also organized.

The content of the information sessions dealt with the kind of stress symptoms that could be expected after having been exposed to violence or to other traumatic events, and what people could do to help themselves and those around them.[2] A complicating factor was that there was so little information available in French. The internationally recruited psychologist played an important role in making the English information available for the Congolese psychologists, and discussing with them if the symptoms and the advice given were relevant for the situation in East Congo. For example, the symptoms that were mentioned in the information sessions were not only symptoms as described in DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, edition IV) or ICD-10 (World Health Organization's International Classification of Diseases, edition 10). As Medairs' psychosocial team had met a lot of traumatized people

(during the first years of their project) with psychosomatic symptoms (such as headaches, hypertension and gastritis), these symptoms were also discussed in the information sessions. In short, the main message of the campaign was that stress symptoms were not easy to cope with, but that they were, in fact, normal reactions to abnormal situations and events[3]. Participants were encouraged to talk about their feelings, and to share their experiences with people they trusted. Expressing your feelings through words and conversations seemed to be new to the people of this area. In rituals and songs, feelings were expressed, but to talk about them (and not only with a spiritual leader) was, before the sessions, not considered as a serious solution to problems. The chief of the village, or community, and the pastors had an important role in dealing with problems, but their help was quite often either just spiritual (praying with the victim or encouraging a victim to pray and to attend church services) or focused on material compensation (in case of damage of goods, or in case of sexual violence – loss of virginity). These religious and community leaders were an important target group of the campaign. By targeting these key people, Medair hoped to give them extra tools to help the people who came to them for support.

In general, people received one information session of around two to three hours. In some places, a one-day session was organized, followed by a follow-up session one month later in order to ascertain if important questions had arisen. Participants of the sessions were not trained to set a psychiatric diagnosis, but they did receive information so as to recognise symptoms as reactions to traumatic stress.

The information sessions were held in French or Swahili, according to the needs and capacities of the participants. As supporting material, all participants received a flyer in French and/or Swahili. The content of the flyer covered the same topics as the information sessions: what symptoms can be expected and what can be done to take care of yourself and your family?

The participants of the full-day training each received a syllabus; the other participants shared their syllabus (two or three per school). All syllabuses were written in French. The targeted communities and schools also received posters (in French and Swahili). Apart from this, Medair also did radio broadcasts on the same topics. However, in some rural areas these broadcasts could not be received.

Results

In order to evaluate the increase of knowledge, two weeks before and two weeks after the information session, written questionnaires (pre- and post tests) were distributed to a sample of those who participated in the information sessions. The questionnaires were written in French, (a language that most people use daily and can read reasonably well) but the respondents were told that they could answer in their local language, Swahili, if they wished to do so. The questionnaires contained two types of questions: the first about the symptoms of traumatic stress (in this paper called *'symptoms'*) and the second about self help techniques (called *'advice'*).

All groups of participants showed an increase in their level of knowledge about the topics of the information sessions. The increase was bigger for the *'advice'* (compared to the *'symptoms'*). But in both domains there were increases, and the differences between the level of knowledge before and after the sessions were significant for both domains.

Table 1. Increase in knowledge (according to gender)

	Symptoms		Advice		General level of knowledge about traumatic stress	
	Before	After	Before	After	Before	After
Men	1,60	2,17#	1,29	2,54*	2,90	4,71*
Women	1,65	2,36*	1,14	2,34*	2,78	4,70*
Total group	1,59	2,25*	1,21	2,39*	2,81	4,64*

Symptoms: rate from 0 to 3. Advice: rate from 0 to 3. Total level: rate from 0 to 6.
* Difference before and after session significant at ($p < 0.001$).
# Difference before and after session significant at ($p < 0.02$).

Interestingly, women are slightly stronger in the more theoretical knowledge about traumatic stress and have a higher score on '*symptoms*' than men, while men score higher on the practically oriented item '*advice*'. These differences, however, were not statistically significant.

Another observation was made about the differences between urban and rural areas, as shown in Table 2. In some rural areas, there was a remarkable lower start level than in urban areas, or rural areas with more industrial activity (like goldmines). However those participants in rural areas where farming was the main income generating activity, still benefited highly from the campaign. The results for '*symptoms*' were still lower than for the 'mining' and 'urban' group, but for '*advice*' they showed results at least as good as the others.

Examples

Some examples can illustrate this increase in knowledge. For example, after the sessions, the answers were much more concrete than before.

Concerning the symptoms: before the sessions, a lot of participants could not be specific about what symptoms were related to traumatic stress. Before the sessions, symptoms mentioned were problems like; '*lack of intelligence*' and '*newborn babies with physical abnormalities/birth deficiencies*', or causes of traumatic stress were listed as: violence, poverty and war. After the session, symptoms like: *nightmares*, *flashbacks*, *anxiety*,

Table 2. Increase in knowledge (according to area)

	Symptoms		Advice		General level of knowledge about traumatic stress	
	Before	After	Before	After	Before	After
Rural (farming)	1,30	1,85#	0,95	2,41*	2,24	4,26*
Rural (mining)	1,80	2,50	1,30	2,41*	3,10	4,91*
Urban	1,76	2,52*	1,41	2,35*	3,17	4,87*
Total group	1,59	2,25*	1,21	2,39*	2,81	4,64*

Symptoms: rate from 0 to 3. Advice: rate from 0 to 3. Total level: rate from 0 to 6.
* Difference before and after session significant at ($p < 0.001$).
# Difference before and after session significant at ($p < 0.02$).

being ready to flee at any moment, *hypertension* and *avoidance of places related to the traumatic events,* were mentioned.

In the management of problems, the same phenomenon occurred. For example, concerning the question: *Give three examples of practical advice for someone who is traumatized.* Before the session, there were very few concrete answers and participants gave answers like; '*You have to live in peace with everyone*' or '*You have to help the person morally*'.

In other cases, before the sessions, the answers were concrete but not correct; '*You have to avoid talking about traumatic experiences*' or '*The person should stay alone, in a calm and silent place, without any noise*'.

In general, these answers show an avoidance of stimuli that might be linked to the trauma, or avoidance of those situations that might upset the victim (e.g. talking about the event).

Another type of answer that decreased after the sessions were those that showed some sort of passivity of the victims and their feeling of having to wait for professional help; '*Consult a psychologist*' or '*Go to a hospital*'.

After the information sessions, the advice was more concrete and practical, and showed a more active attitude; '*You can talk with other victims*', '*Try not to stay alone*', *You should not avoid negative memories by drinking alcohol*', *Don't isolate yourself*' and '*Help a traumatized person, just by being with him, don't leave him alone, even if he doesn't want to talk.*'

Discussion

As the results of the campaign were so positive, Medair decided to continue it. In areas where Medair had a programme for the support of victims of sexual violence. They also decided to combine the existing programme with a sensitization programme. Results of the evaluation of this sensitization campaign are not yet available.

The answers to the questionnaires were very useful in adapting the sessions. A lot of participants thought, for example, that the isolation of a victim was the best strategy. While for Western psychologists this does not seem to be the most appropriate coping mechanism, it is understandable how people might come to the conclusion that traumatized people should be left alone. For example, those suffering from flash backs, might react unpredictably to sudden noises. In turn, these unpredictable reactions can be frightening for others. Other survivors might be easily irritated and react very angrily to small frustrations, which is difficult for others to understand and cope with as well.

As a result of the questionnaires, Medair was concerned that a strategy of isolation might have been appropriate in this culture and situation, but after consultation with their Congolese psychologists, this was found not to be the case. So in the sessions, Medair insisted that you should not allow a victim to isolate him or herself too often. When it was explained why isolation was not a good strategy, participants of the sessions reacted with understanding and a willingness to change their attitude.

The extent to which attitudes and coping strategies really changed was hard to measure in this evaluative research. In fact, what was measured with the pre- and post tests was more the capacity of retaining information and memorising. Nevertheless, in our project, we did not find evidence that would cast doubt on the efficacy and applicability of the information sessions. Testimonies from participants (during supervisions) showed that they applied what they had learnt; however, we do not have exact figures about precise behavioural changes.

Some interesting observations still await an explanation. For example, is the good result that was seen in rural 'farming' areas due to the full day session? This cannot be the only reason, because the group in the 'mining' area also received a full day session. Also, it does not explain why in these areas, the increase is mainly about the *'advice'* and less about the *'symptoms'*. Are people in farming areas more focused on the practical 'how to' knowledge, rather than on theoretical 'what is' knowledge? We also had the impression that the differences observed within those rural areas had to do with the level of education of the participants. We don't have exact figures for this variable, but we do have the impression that the level of education in rural areas where farming is the main activity is lower than in rural areas where there is a lot of mining.

We are very aware of the fact that information alone is not enough to help those who suffer from severe symptoms of traumatic stress. Medair has already trained several groups of counsellors who could offer more professional help, but the problem is how to integrate that support that counsellors could offer into a sustainable system. To set up a new organization providing mental health services is not within Medair's capacity (quite apart from the question of *if* humanitarian organizations should set up new mental health systems). Medair is now trying to implement some knowledge about mental health and traumatic stress into the primary health care system[4]. However, for the population, mental health is such an unknown area that the risk is that every mental health problem will easily be labelled as traumatic stress, if the focus is only on trauma-related problems. To avoid this, sensitization campaigns can play an important role.

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[1] The availability of literature was quite limited as we worked in a remote area. Most sources were from the internet. Sphere Guidelines were consulted from www.sphereproject.orzg.

[2] Websites of the National Centre for PTSD (www.ncptsd.va.gov), of the National Institute of Mental Health (www.nimh.nih.gov) and of the World Health Organization (www.who.int/mental_health) were used for the selection of topics for the information sessions.

[3] Slogans used in flyers and on posters were for example: *'Mon enfant s'endort difficilement depuis notre fuite, c'est normal?'* (*My child has sleeping difficulties since we have fled, is this normal?*) On the posters, those slogans were followed by a short explanation and by advice on what to do with, for example, children with sleeping difficulties. The flyers also contained more information about traumatic stress, its symptoms and coping strategies.

[4] This could be the first step towards the implementation of mental health services in the primary health care system, an approach that is also applied in other developmental countries (e.g. Tanzania).

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