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A Psychosocial Program for Liberian and
Sierra Leonean Survivors of Torture and War**

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From 1999 to 2005, the Minneapolis-based Center for Victims of Torture (CVT) served Liberian and Sierra Leonean survivors of torture and war living in the refugee camps of Guinea. A psychosocial program was developed with 3 main goals: (a) to provide mental health care, (b) to train local refugee counselors, and (c) to raise community awareness about war trauma and mental health. Utilizing paraprofessional counselors under the close, on-site supervision of expatriate clinicians, the treatment model blended elements of Western and indigenous healing. The core component consisted of relationship-based supportive group counseling. Clinical interventions were guided by a 3-stage model of trauma recovery (safety, mourning, reconnection), which was adapted to the realities of the refugee camp setting. Over 4,000 clients were provided with counseling, and an additional 15,000 were provided with other supportive services. Results from follow-up assessments indicated significant reductions in trauma symptoms and increases in measures of daily functioning and social support during and after participation in groups. The treatment model developed in Guinea served as the basis for CVT's ongoing work with survivors in Sierra Leone and Liberia.

Keywords: torture survivors, war trauma, African refugees, psychosocial programs, refugee mental health

Editor's Note

The Center for Victims of Torture–Guinea 2004–2005 International Mental Health Team received the International Humanitarian Award. Award winners are invited to deliver an award address at the APA's annual convention. A version of this award address was delivered at the 114th annual meeting, held August 10–13, 2006, in New Orleans, Louisiana. Articles based on award addresses are reviewed, but they differ from unsolicited articles in that they are expressions of the winners' reflections on their work and their views of the field.

Torture has existed since time immemorial.¹ The movement to develop specialized programs for rehabilitating survivors, however, is relatively young. During the 1970s, a small number of individuals and facilities in regions that had been plagued by political repression and ethnic violence offered limited clinical services for survivors. At the end of that decade, Amnesty International began to address the complex medical, legal, social, and psychological needs of survivors by creating a network of over 4,000 physicians in 34 countries (Center for Victims of Torture, 2005). The Rehabilitation and Research Centre for Torture Victims was established in Copenhagen, Denmark, in 1982; the Canadian Center for Victims of Torture was launched in Toronto the following year. Since then, the movement has grown exponentially; there are now over 250 treatment centers for torture survivors, located in over 75 countries (Johnson, 2004; Quiroga & Jaranson, 2005).

The Center for Victims of Torture (CVT) was founded in Minneapolis, Minnesota, in 1985 and was the first organization in the United States dedicated to providing care and rehabilitative services to survivors of politically motivated torture. Over the past two decades, CVT has emerged as an internationally recognized provider of psychosocial training and direct care. Currently, CVT works with over 35 organizations and programs serving torture survivors in the United States, as well as 16 organizations around the world, to improve their capacity to provide specialized services.

In its clinics in Minnesota, CVT's work is geared mainly toward those torture survivors who have fled their countries of origin and reside in the United States. In its early years, the majority of CVT's clients were from Southeast Asia, followed by a substantial number from Central America and later from Bosnia and the Middle East. Beginning in the 1990s and continuing to the present, increasingly large numbers of people of African origin have sought treatment at CVT. Presently, over 90% of CVT's clients are from Africa; of these, over half are from the West African region.

In recognition of the experience and expertise that CVT had developed working with West African torture survivors, in early 1999 the U.S. State Department Bureau of Population, Refugees, and Migration requested that CVT develop a program to meet the mental health needs of Sierra Leonean refugees in Guinea. CVT viewed this request as an opportunity to reach a population of torture survivors that had long been overlooked. Although CVT was serving hundreds of clients in its Minnesota clinics, these individuals represented only a fraction of the torture survivors worldwide who were in need of treatment. The reality is that the vast majority of torture survivors live in the lands of their birth or as refugees in neighboring countries, and do not have access to

specialized care. CVT's services in Guinea initially were intended primarily for Sierra Leoneans, but Guinea's geographic location meant that Liberians also fled there for refuge. During its tenure in Guinea, CVT served both Sierra Leoneans and Liberians, populations that shared a similar and intertwined history of large-scale violence.

Historical Background

In Liberia in 1989, the National Patriotic Front of Liberia, led by Charles Taylor, launched an uprising against the Samuel Doe government. In 1990, a Nigerian-led West African regional force (ECOMOG) was dispatched in an effort to establish peace, but later that year, rebels from a splinter group murdered the president, and Liberia descended into a chaotic civil war. For the next five years, there were several tentative ceasefires and disarmament efforts, punctuated by re-escalations of violence. Between 1989 and 1996, hundreds of thousands of Liberians fled across the border to seek refuge in Guinea. By August 1996, a measure of stability appeared to have been re-established, and large numbers of these refugees were repatriated. In July 1997, Charles Taylor was elected president. War erupted again in 1999 when anti-Taylor forces invaded Liberia; Taylor's forces launched a massive offensive against these rebels the following year. In 2002, more than 50,000 Liberians and Sierra Leoneans fled the escalating violence to seek refuge in neighboring countries. In June 2003, Taylor was indicted by the United Nations-backed Special Court for Sierra Leone for war crimes committed on Sierra Leonean territory; two months later, as the rebels closed in on Monrovia, Liberia, Taylor was forced into exile, and peace was restored. At the end of March 2006, Charles Taylor was

¹ In the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, torture is defined as

any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. (United Nations General Assembly, 1984, Article 1)

The *Convention Against Torture* is the most widely recognized legal and political definition of torture. The *Declaration of Tokyo: Guidelines for Physicians Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* defines torture as

the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason. (World Medical Association, 1975)

extradited from Nigeria and brought to Freetown, Sierra Leone, to stand trial in the Special Court.

The war in Liberia spread across the border into Sierra Leone in 1991, when the Revolutionary United Front, led by Foday Sankoh and supported by Charles Taylor, launched an uprising against the democratically elected president. This precipitated a long period of instability and violence, including three military coups and a failed peace agreement over the following seven years. The situation appeared to have been stabilized in 1998, when with the assistance of ECOMOG, the rebels were driven out of Freetown, and the president returned from exile in Guinea. In January 1999, however, the Revolutionary United Front invaded Freetown, killing 5,000 people and wreaking havoc throughout the capital. The United Nations intervened, a ceasefire was established, a peace agreement between the government and the rebels was signed, and United Nations troops arrived to enforce this agreement. Nevertheless, for the next two years, the situation remained unstable. In May 2001, disarmament of the rebel forces finally began, and in January of the following year, the war was declared over.

Refugees from Sierra Leone and Liberia have endured some of the most horrific and violent atrocities in human history. The wars in both countries were notorious for their extreme brutality. Rival factions were responsible for the deaths of more than 300,000 civilians (250,000 in Liberia; 50,000 in Sierra Leone), including an estimated 50,000 children. Mass terrorization of entire villages and towns was routine. Common practices included summary execution, systematic rape and enslavement of women, abduction and use of children as soldiers, and wanton destruction of property. Thousands were maimed, and over two million civilians were displaced. By the turn of the century, Guinea was host to the largest concentration of refugees on the continent of Africa, hosting nearly 480,000 individuals from these two adjoining countries.

War atrocities frequently described by these refugees included intentional hacking off of limbs, carving the initials of rebel factions into victims' skin, slaughtering pregnant women to bet on the gender of the unborn child, and use of young girls as human sacrifices. Numerous people have reported that they were forced to cut, cook, eat, and serve human flesh and internal organs, including those of their own parents and infants. Countless numbers of children and teenagers were forced to watch the torture, rape, and brutal murders of their parents and siblings. In many cases, family members—including children—were forced to rape, murder, and mutilate each other. During these acts, victims were forbidden to show any emotion or, in many cases, were commanded to laugh. In some instances, people who shed tears in response to these atrocities were punished by being permanently blinded. In regions where attacks occurred, large

portions of the population had to hide in the dense and inhospitable forest for long periods without food or water, and had to walk for many miles to seek refuge, often falling into ambushes along the way. Large numbers were beaten, robbed, extorted, and humiliated when attempting to cross national borders into safety. Women and teen girls frequently reported that they were raped by Guinean soldiers at the border while seeking protection.

The results of CVT's initial needs assessment in Guinea clearly indicated that these experiences of torture and war atrocities had left profound psychological scars. A large proportion of the refugees were suffering from depression, lethargy, hopelessness, anxiety, and posttraumatic stress. Many were unable to make meaningful contributions to their families and communities. Most found it difficult to imagine rebuilding their lives.

CVT's West Africa Programs

CVT began working in Guinea in November 1999, initially based in Gueckedou, a town near the borders of Liberia and Sierra Leone (Hubbard & Pearson, 2004). Rebels attacked Gueckedou in the fall of 2000, however, and refugees were forced to relocate further inland to Kissidougou, a small town in the forest region, located 10 hours by road from the country's capital, Conakry. CVT was mandated to offer mental health services in four refugee camps in this region, called the Albadariah camps. During its first two years of existence, the program served primarily Sierra Leoneans. By late 2001, the violence in Sierra Leone was beginning to subside, and the Sierra Leonean refugees slowly started returning home. Just as the Sierra Leoneans were repatriating, however, Liberia again exploded in civil war, and tens of thousands of new Liberian refugees fled to Guinea. Thus, in the final two years of the program (April 2003–March 2005), the clients were almost exclusively from Liberia.

In fall 2001, in response to the repatriation of the Sierra Leonean refugees, CVT also began operating in Sierra Leone, to serve returning refugees as well as those who had stayed in Sierra Leone throughout the war. CVT–Sierra Leone also served Liberian refugees who fled to Sierra Leone during the re-escalation of the war in Liberia. Following the signing of the peace agreement and the departure of Charles Taylor, the United Nations High Commissioner for Refugees began repatriating Liberian refugees in late 2004 and early 2005. At the end of March 2005, CVT–Guinea closed, and CVT–Liberia was established. Both CVT–Sierra Leone and CVT–Liberia were modeled on the program developed in Guinea and continue to provide services to thousands of survivors.

CVT–Guinea Overview

CVT–Guinea had three main, interconnected objectives: (a) the provision of psychological and psychosocial ser-

vices to address mental health problems experienced by refugee survivors of torture and war trauma, (b) the enhancement of community capacity to meet the mental health needs of torture survivors and other refugees through the provision of training and supervision for local refugee counselors, and (c) the raising of awareness about torture, war trauma, mental health, and related issues throughout the camps through a combination of training community leaders and conducting campwide sensitization campaigns.

The program was supervised by six expatriates: a country director, a field coordinator, and four clinicians. The academic and professional backgrounds of these clinicians included psychology, psychiatric nursing, child development, and clinical social work. Most clinicians remained for one year, although some stayed longer. These expatriates came from a variety of countries (e.g., Kenya, Spain, the Philippines, Chile, Japan, the Netherlands, South Africa, the Democratic Republic of Congo, Nepal, and the United States), represented diverse religious and socioeconomic backgrounds, and ranged in age from late 20s to early 60s. Clinical staff were required to have had extensive prior experience with victims of ethnonopolitical trauma from multicultural populations.

The CVT-Guinea program included the following components: (a) training of refugee paraprofessional counselors, (b) clinical services, (c) social activities, (d) training of community leaders and other service providers, and (e) community awareness campaigns. Although the clinical services were the core component, the other elements are briefly described to provide a thorough and accurate picture of the nature and scope of the project.

Training of Psychosocial Agents

To meet the mental health needs of the thousands of traumatized refugees in the Albadariah camps, we recruited a cadre of refugees who, in spite of having only a high school education, evidenced strong potential for becoming competent paraprofessional counselors. These individuals, referred to as psychosocial agents (PSAs), were carefully selected after a rigorous and highly competitive screening process. They were then provided with initial, intermediate, and advanced training in mental health, counseling skills, trauma theory, child development, group dynamics, treatment planning, family and community interventions, and related topics, as well as in language interpretation skills. Learning material was continually reinforced through close monitoring and on-the-job training.

The expatriate clinicians spent four days a week in the camps providing direct, on-site supervision of all aspects of PSAs' work (e.g., psychosocial assessments, treatment plans, counseling). They would meet with the PSA cofacilitators to help plan before each group therapy session, intervene directly as needed during the session, and

debrief afterward to give feedback to the PSAs and to assist the PSAs with countertransference and vicarious trauma. Over a period of five years, CVT-Guinea trained and supervised over 80 PSAs; the first cohort comprised mainly Sierra Leoneans and the second Liberians.

Many CVT trainees reached a level of competence where they were eventually able to run their own counseling groups with limited supervision; the most promising underwent an in-depth training of trainers and ultimately took on many of the same responsibilities as the expatriate psychologists. A large proportion of the PSAs who were employed in Guinea have continued to work with CVT since their repatriation. Over half of those who returned to Sierra Leone were able to obtain a diploma in psychosocial counseling from a local university (the equivalent of an associate's degree), primarily as a result of the training and experience they had acquired in CVT. Two PSAs from CVT-Guinea currently work as counselors for witnesses who are testifying in the United Nations-backed war crimes tribunal in Sierra Leone. Most of the Liberian PSAs from CVT-Guinea are now working for CVT-Liberia, helping to build the beginnings of a mental health infrastructure for their war-torn country.

Clinical Services

CVT-Guinea was responsible for four community mental health centers in the Albadariah camps, each serving an average of 300 clients per year. A variety of clinical services and modalities were offered, with supportive group psychotherapy as the primary approach. Later in this article, we provide a detailed description of the treatment model.

PSAs conducted psychosocial assessments at intake and at 1, 3, 6, and 12 months thereafter. PSAs regularly visited vulnerable clients in their homes to reduce isolation, monitor well-being, and encourage renewed participation in the community. Individual counseling was offered to those who were not ready, emotionally or socially, to be in a group. In some cases, particularly those in which the trauma symptoms were severe, individual and group counseling were provided concurrently. Family counseling included parent-child, couples/marital, parent/caretaker, and family systems approaches. A group intervention for parents and caretakers of child clients was also offered, with topics such as the following: the effects of trauma on parents and children, meeting children's emotional needs, responding to children's behavioral problems, nonviolent disciplinary methods, childhood bereavement, and talking with children about difficult topics.

We recognized that the refugees with whom we worked had a variety of physical, psychosocial, and material needs in addition to the need for counseling. Therefore, CVT worked in close partnership with the United

Nations High Commissioner for Refugees and with other nongovernmental organizations. PSAs and clinicians actively advocated for clients in regard to numerous areas of concern (e.g., family reunification, child abuse, domestic violence, medical care, education, shelter, food assistance, protection).

Social Activities

PSAs, under the direction of the clinicians, led social activities for large groups of refugees in order to build resilience, promote social interaction, and provide CVT's counseling clients with an opportunity to expand their social networks. Activities included art making, team sports, games, sandbox play, music, and storytelling. During these activities, PSAs were able to observe the non-clients and identify any who might benefit from treatment. For example, if a child appeared sad and withdrawn, the PSA might follow up with the child and his or her caregiver and, if appropriate, might offer an appointment for a formal psychosocial assessment. During CVT's tenure in Guinea, over 15,000 refugees participated in these large-group activities.

Training of Community Leaders and Other Service Providers

In addition to our intensive and continuous internal training of the PSAs, we also provided training to de facto counselors and problem solvers in the wider refugee community. These trainings focused on helping participants improve their skills for working with survivors of torture and war, their understanding of the importance of self-care, and their ability to determine when to make referrals for mental health services. Participants included advocates from a legal aid clinic for refugee women, child-care workers from a nongovernmental organization, grassroots cultural workers, hundreds of community and religious leaders, and the majority of the teachers and health care providers in the camps in which we worked.

Community Awareness Campaigns

CVT's mission is not only to heal the wounds of torture, but also to prevent torture worldwide and to ensure that societies are equipped to respond to the needs of survivors. Therefore, an important feature of the program was monthly campwide campaigns to raise awareness of the ways that torture and war affect individuals, families, and communities. During its tenure in Guinea, CVT conducted over 200 large-scale community awareness events, reaching a total of more than 8,000 refugees.

These campaigns were designed and conducted by PSAs, with the guidance of the expatriate clinicians. Methods included dramas and role playing, musical performances, facilitated dialogues, posters, cultural stories, and in particular, the problem-posing method pioneered

by Brazilian educator Paulo Freire. In this method, a poster depicting experiences that are of major interest and importance to the target population is used as a catalyst for dialogue, reflection, and action planning.

In addition to these community sensitizations, CVT also raised public awareness by conducting special events. These included annual commemorations of the United Nations International Day in Support of Victims of Torture and a Speak-Out on recovery from torture and war trauma. Also, CVT assisted partner nongovernmental organizations in carrying out campwide sensitizations on human rights issues. In many instances, voluntary participation in these public events served as an important component of the healing process for CVT's clients.

Contextual Considerations

In seeking to design a program for survivors of torture and war atrocities in a refugee camp setting, we considered a number of issues. First, the traumatic experiences were extreme and pervasive. Of the more than 20,000 refugees who resided in the Albadariah camps at any given time, the vast majority had had direct exposure to severe violence. Large numbers had undergone torture.

Second, among the most common psychological sequelae of torture and war atrocities are feelings of isolation and stigma. This psychological sense of being set apart from the rest of humanity was reinforced by the physical remoteness of the camps (i.e., over 10 hours from the capital by road) and the lack of access to transportation, electricity, and means of communication with the outside world (e.g., telephones, Internet, mail). Moreover, there were significant restrictions on movement, and any travel outside of the camps had to be approved by authorities.

Third, life in the camps was characterized by severe hardships and scarcity. In particular, hunger was widespread, medicines were in short supply, and shelters were vulnerable to rain and wind. Opportunities for employment and income generation were extremely limited. Refugees lacked control over many basic aspects of their daily lives. Feelings of vulnerability and powerlessness, which are commonly observed psychological consequences of torture and war, were exacerbated by this actual lack of control. In such a setting, networks of social support are crucial for daily survival, yet the natural networks that had existed in their native towns and villages had been largely destroyed. Further, there were reports of rampant corruption and exploitation by fellow refugees, Guinean authorities, and even some staff from humanitarian organizations.

Fourth, refugee camps are inherently temporary settings. Residents of these camps are eventually required to return home, integrate into the local population, or seek resettlement in a third country. Entire camps could be

closed, and/or the occupants could be relocated, regardless of their wishes. This sense of uncertainty about the future is intensified by the fact that most refugee service providers operate on a time-limited basis and are dependent on donor funding, which can vary from one year to the next or even from month to month.

In summary, it was important to be capable of reaching large numbers of people without compromising quality of care. Moreover, it was necessary to enhance clients' capacity to form meaningful interpersonal relationships and establish new social support systems. The program was designed to effectively address these realities.

Treatment Model

Our work was informed by a stage-oriented model of trauma recovery (Herman, 1992). In this approach, safety and a caring relationship serve as the foundation for later exploration of traumatic experiences and their associated emotions (e.g., fear, shame, guilt, loss, sorrow), culminating in an eventual reconnection with self, others, and life. Although it was necessary to adapt this model to the realities of the refugee camp context, we nevertheless attempted to honor its spirit.

The theoretical foundations for the model included elements of psychodynamic, relational/interpersonal, cognitive-behavioral, narrative, and expressive/humanistic psychotherapies. The building and encouragement of interpersonal connections was the primary aim. Another key idea was that there are psychological benefits to representing intense affect-laden experiences in words or other symbolic forms (e.g., drawings, drama, songs). Our work was also informed by aspects of the academic/professional discipline of community psychology (e.g., training of paraprofessionals, promotion of resilience, social support, advocacy, public awareness campaigns).

Clinicians had a measure of freedom to practice in a manner consistent with their own professional orientation and style. Although this flexibility had some drawbacks in comparison with a fully standardized approach, it allowed for maximum clinician creativity and enabled the PSAs to be exposed to a wide variety of approaches. As clinicians of different theoretical orientations served in the program, they contributed a variety of specific techniques. Ultimately, we incorporated into the model those that were most effective with our population.

A hallmark of our work was the combination of Western and African approaches. Circular mud-brick huts with thatched roofs, built with locally procured materials and in a traditional style, served as counseling huts, designed to provide a sense of safety, comfort, and familiarity for the clients. The fact that the paraprofessional group facilitators were themselves refugees living in the camps helped to ensure that the treatment methods would be

culturally sensitive. Elements of traditional West African culture that were incorporated into many of the groups included healing rituals, symbols (e.g., offering kola nuts to welcome newcomers), traditional stories, drumming, chants, rhythmic clapping, and song.

Most groups met for 10 weekly sessions of about two hours each, although the exact number of sessions was tailored to the participants' needs as well as exigencies of life in the camp. Groups typically comprised 9 or 10 clients (with an average attendance of 7 or 8 members per session) and were led by 2 PSAs, one of whom also served as a language interpreter for the supervising clinician (and/or for members of any linguistic minorities in the group). (Although English is the official language of Liberia and Sierra Leone, many clients spoke only the language of their own ethnic group.) Groups were formed according to age (e.g., children, teens, adults), gender, and commonality of traumatic experiences.

In the first stage, the chief task was the establishment of safety, which in our context meant primarily the stabilization of physical, emotional, and behavioral symptoms and the creation of a trusting, reliable relationship with the paraprofessional counselor. Consistent with these tasks, the PSAs were encouraged to demonstrate their trustworthiness and reliability from the earliest contact, namely, the intake assessment. Clients were informed of the nature and limitations of our services and of the types of themes that would be explored in the group. Group members generated a list of ground rules that they determined would help them feel safe (e.g., confidentiality, respect). We attempted to explain the purposes of the group in terms that clients could readily understand, sometimes using metaphors or analogies. While being careful not to make false promises or encourage expectations of a miraculous and total recovery, it was suggested to clients that they could feel better than they did presently and that they could heal and recover substantially, although doing so would require a sincere commitment on their part. We affirmed that no matter what they had experienced, they could go on to live productive and meaningful lives.

From the orientation session on, we sought to support clients in developing safe, caring relationships with each other. In contrast to many traditional Western group psychotherapy approaches, which restrict contact among group members outside of sessions, in our groups contact among members between sessions was encouraged. Often, clients mistakenly assumed that they should narrate their trauma story in the first few sessions. Consistent with our goal of building safety, however, we sought to set limits on the premature emergence of traumatic material. During introductions, we would encourage participants to share with one another their name, their age, their place of origin, how long they had been in the camp, and their favor-

ite activities but little else. Also, during the first stage, we invited clients to share about their lives *before* their experiences of torture and war. We felt that sharing about their lives before the war would assist the group members in building trust and connection in preparation for later sessions that would deal with more difficult material. We also sought to support the development of a more coherent narrative framework for recognizing the impact of the torture and/or war on their lives.

An early Stage 1 intervention, which was enriched and elaborated on throughout the cycle, was called "naming feelings," in which we used a variety of exercises designed to assist clients in finding and using precise, accurate words to describe their own emotions and those of others. In Liberian culture, it is common to use general terms, such as *feeling bad*, to describe a very wide range of emotions. We felt that supporting clients in developing a capacity to choose more specific verbal representations of their internal states would contribute to a sense of relief and a possibility of being more accurately understood by others, and we felt that the medium of language could give form and containment to otherwise overwhelming sensations, perceptions, and affect.

At Stage 1, we also provided clients with psychoeducation about torture and war trauma, using methods such as dramatic monologues, posters, and skits. One example was a poster depicting a child in a classroom in which the teacher was attempting to give a lesson, but the child was distracted by intrusive images of events from the war. Another was a skit performed by the co-facilitators portraying a woman who became extremely startled by a minor sound. The posters and skits were used as a springboard for inviting the clients to share about the impact of their own experiences of torture and war.

In addition to common posttraumatic symptoms, such as nightmares and hypervigilance, themes that tended to arise included loss of innocence and the capacity for lightheartedness and joy, damaged self-image, deterioration in the quality of relationships with family members, and the feeling that nobody would be able to understand. When clients would describe these sequelae, the facilitators would comment on some of the shared underlying themes and support the articulation of feelings. Facilitators also attempted to normalize the common symptoms and to acknowledge frankly but sensitively that torture and war trauma do change people, while also emphasizing that with time and support, people can become stronger and can learn ways to cope with these changes.

The clients seemed relieved to learn that their symptoms (e.g., nightmares, startle reactions) were normal and that others were suffering in similar ways. Clients appreciated the opportunity to compare and contrast their reactions with those of their peers and to learn practical techniques for managing their symptoms more effectively

(e.g., mindful breathing). Using role playing, skits, posters, and discussion, we demonstrated grounding techniques for coping with nightmares and other intrusive symptoms. Clients expressed appreciation for these coping tools and reported that they continued to use them even after the group cycle ended.

We used a variety of methods for building connections among group members. We checked in with members at the beginning of each session, so that they developed an awareness of each other's day-to-day struggles in the camp. PSAs endeavored to serve as models of empathic interpersonal communication. In the first session, we often used an exercise in which participants first try to break a single stick (which is easy) and then try to break a bundle of eight sticks (which is difficult or impossible), to convey the idea that they could be stronger together than apart. With children and teens, after providing each group member with an opportunity to share about a picture he or she had drawn, we often invited the group members to place all the drawings simultaneously on the floor of the hut and to observe any features they had in common (of which there were usually many). When a group member would share, the facilitator might ask the other group members, "What touched your heart most in what he or she just told us?" The other participants would then share their responses.

One of our techniques, derived from cognitive therapy, was teaching clients to engage in positive self-talk. Initially, we found that there was a tendency for some clients to generate self-statements that were not reality based. For example, a person who had witnessed several close relatives being violently killed chose the statement "I will forget about it soon." We found that in order for positive self-talk to be effective, we had to support the clients in generating statements that were truthful (e.g., "I did the best I could").

To help clients more fully grasp the technique of replacing negative self-talk with positive self-talk, the co-facilitators sometimes performed a skit called "The Two Hearts" (in Liberian English, *heart* refers to one's mood or state of mind). This skit depicted a person who felt torn between an encouraging attitude about his or her life and a discouraging, self-defeating attitude, and who ultimately is able to choose the former. A variation on this was an exercise called "Talking Back to Discouragement," which drew on principles from psychodrama and from narrative, body-oriented, and dance/movement therapies. In this version, participants would first generate a list of negative thoughts, which they acknowledged as exacerbating their despair, and a facilitator would then embody Discouragement, approaching each group member one at a time while giving voice to the pessimistic thoughts that he or she had listed (e.g., "things will never get better," "the situation is hopeless"). Group members

were invited to rise and push against the facilitator's hands while talking back to him or her in a strong tone (e.g., "You're wrong! I have survived hard times before, and I will survive this too"). Facilitators reported that this exercise appeared to have a special cultural resonance, as many of the clients' indigenous traditions featured supernatural entities (e.g., bush devils) that personified particular attributes.

The middle part of the group cycle focused on emotional, cognitive, and verbal processing of traumatic memories. During this part of the cycle, clients narrated their trauma stories in the presence of compassionate witnesses and allowed themselves to feel the full range of emotions associated with their stories in a contained environment (i.e., the group). There was considerable debate among clinicians about how much trauma narration should be done within the groups (vs. in individual sessions) and how it should be managed. Ideally, this task was attempted only after a reasonable measure of safety had been established. The particular interventions and techniques at this stage varied according to the needs and composition of the group.

In some groups, clients were invited to share about a time they had felt afraid and/or about their most difficult experiences. Sometimes we would propose that they depict their experience first in a drawing and then use the drawing as a basis for sharing. The drawings—which typically portrayed painful memories of torture, rape, and murder—helped to provide focus and containment in comparison with a purely oral approach. We could not use drawings in every group, however, because many clients (especially the women) had never been to school and thus were not familiar with using pencils. In these groups, the facilitators would ask open questions to help the clients explore their memories and emotions. As clients would answer, facilitators would listen, paraphrase the essence of what had been shared, validate and normalize their emotions, and express empathy, while also providing group members with an opportunity to express empathy for one another.

At the same time, the facilitators were implicitly conveying the idea that nothing is too scary to be talked about. We have been influenced by the axiom "what is mentionable is manageable, what is unmentionable, is unmanageable." Thus, we believed that the events would be less overwhelming if they could be talked about and if these stories could be borne by the facilitators and other group members. In addition, to reduce feelings of stigmatization and shame and to strengthen connections among the group members, it was helpful to highlight the commonalities among them. Although torture is a very individual experience, there were usually important similarities in their stories.

Loss and grief formed another key area that we addressed midway through the cycle. Refugees from Liberia and Sierra Leone suffered massive losses from the wars. Most lost several close relatives, and many lost their entire immediate families. Most also had relatives who remained missing. Very often, the brutal murder of loved ones was a method of torture perpetrated against the survivors, a method intended to humiliate, subjugate, or terrorize them and the entire community. In addition, quite frequently the loved ones themselves were tortured prior to being killed.

Although clearly there were no simple remedies and nothing could completely erase the pain of such massive losses, in our group counseling sessions we offered a safe, contained space within which clients could feel and express their grief. Our view was that grief tends to be more overwhelming and terrifying when people feel isolated and unsupported. By contrast, when grieving people are provided with empathy and support, the pain can become more bearable, and they can usually regain a capacity for hope and a sense of meaning and purpose in their lives.

Our view was that genuine and deep mourning was a precondition for healing. Thus, we attempted to facilitate processes whereby clients could begin to mourn their losses. In a safe space, they could explore their fears, anger, helplessness, agony, and despair. Clients appeared to benefit from having someone who was willing to listen to and hold their full expression of shock, hopelessness, protest, fear, and bottomless pain. Once the grief was expressed, the intensity of the anguish tended to slowly lessen, and the client could usually find interest in life once again.

The particular techniques we used varied according to clinician orientation and client needs. At times, clients would draw a person or persons whom they had lost and then share about their drawing. The extremely violent manner in which most victims of the Liberian and Sierra Leonean wars were killed resulted in a tendency among clients to focus intently on their loved ones' manner of death, often to the exclusion of all the positively toned, consoling images of the years preceding the death in which the loved ones were usually nurturing, caring figures in the clients' lives. Thus, although we acknowledged the normality of painful memories about manner of death, we attempted to support clients in remembering as much as possible about the lost person's life as a whole and, in particular, in revivifying a positive, life-affirming internal representation of their loved ones as they truly were in life, thereby counterbalancing the horrific images of violence with images of being succored and loved.

Usually, it was also important to allow time for clients to explore their feelings about not having been able to perform traditional ceremonies and rituals following their

loved ones' deaths. As a result of the constraints of the war situation, in which the survivors themselves were typically captured, injured, struggling to survive in the bush, or attempting to flee into refuge, it was often impossible to carry out the rites that would normally be expected in peacetime, such as a proper funeral and burial. Some clients expressed a desire to perform some type of bereavement ritual in the camp. We encouraged them to fulfill this desire to the extent that they were able in the refugee camp setting, in which traditional religious leaders and objects were usually lacking. More often, however, drawing on the idea that words could serve as a substitute for action, we verbally explored the mourning practices and rituals that each group member would have performed if he or she had not been robbed of the opportunity. Group members appeared to enjoy being able to share about their ethnocultural bereavement practices and to learn about those of others. They gained some relief from representing these practices in words, even without being able to actually implement them.

The interventions we chose to use in supporting clients to explore their losses and grief were informed by the *continuing bonds* view of bereavement (Klass, Silverman, & Nickman, 1996). In this view, the bereaved do not typically de-cathect their lost loved ones as was believed in previous psychological models of grief, but rather search for meaningful and culturally appropriate ways of remembering and honoring connections with them for the rest of their lives. Thus, we supported clients in developing a sense of a positive bond with a lost loved one. Although in many Western settings this might be experienced as an as-if type of process, in which the positive representation is perceived as internal and subjective, our clients tended to experience an authentic and potent sense of actual spiritual connection with the soul of the lost one.

We used a variety of specific techniques to achieve these therapeutic aims. One was a guided visualization in which group members closed their eyes and imagined that they were speaking to their loved one and that their loved one was speaking to them in reply. A variant of this was inviting each client to write a letter saying whatever he or she would like to say to the lost person. The client would then write a letter to himself or herself in the persona of the lost one. The messages or letters could then be shared with the group.

A third version, derived from a Gestalt therapy technique, was an exercise in which two chairs would be placed in the center of the hut, facing each other, and each client would take a turn sitting in one chair and facing the empty chair while imagining that his or her loved one was seated there; the client would say whatever he or she wished to say to the loved one and would then switch to the empty chair and imagine himself or herself as the lost one, looking across at himself or herself in the empty

chair and responding in the persona of the loved one. Aspects of this exercise seemed consonant with many of the clients' indigenous practices. For example, during funerals and other ceremonies, there is often a spokesperson who directly addresses the spirit of the deceased.

Other interventions we sometimes used around mid-cycle centered on the experience and expression of anger toward the perpetrator of the torture or war atrocities. Many clients, when asked about feelings of anger in regard to the atrocities perpetrated against them, would reply that they did not feel any anger toward the perpetrators and that they had forgiven them. Although these words sounded admirable in some ways, several clinicians sensed that these statements did not convey these clients' affective experiences fully or honestly. There are people who have undergone a process, often arduous, of experiencing genuine forgiveness toward their perpetrators, yet for many of our clients, facile pronouncements such as "He killed my whole family but I forgive him" seemed to lack the ring of truth.

As a team of clinicians with divergent psychological, religious, and cultural orientations, we struggled with the question of how best to respond to such pronouncements. Some felt that the focus should be on themes of forgiveness and reconciliation, whereas others felt that it was important to first acknowledge and explore the anger that was evident in many of the clients. Some believed that righteous indignation about torture was appropriate and healthy and that forgiveness for torture and atrocities should not be offered cheaply, but rather should be contingent on the perpetrator's genuine remorse if it was offered at all. Others believed that there was little psychological benefit in focusing on anger and that concentrating on forgiveness and reconciliation was a wiser approach. Ultimately, we attempted to give attention to both concerns by bearing in mind our stage-oriented approach. In Stage 2, interventions offered clients the opportunity to experience and express anger toward perpetrators, whereas Stage 3 interventions included discussion of practical nonviolent strategies for coping with the actual presence of wartime perpetrators in the camps, as well as exploration of deeper issues pertaining to forgiveness and reconciliation. It was, however, widely recognized that most of the larger issues pertaining to peace and reconciliation would need to take place within the context of postconflict civil society and would likely require collective mechanisms for truth-seeking and justice.

In working with anger, we sought to provide clients with a safe, contained environment in which to explore and express their anger about the harm done to themselves and their loved ones. We used techniques such as drawings, expressive writing, and psychodrama to help clients counter feelings of being frightened and intimidated by perpetrators with feelings of strength and em-

powerment, particularly the strength to confront them verbally and nonviolently, either in imagination or in some instances in reality. In addition, in light of the frequent tendencies toward denial, displacement, and projection of anger that we had observed in our work, we wanted to validate that anger at cruelty and injustice is normal and, if expressed constructively, can even serve as a source of energy for social and political change. Finally, we wished to support clients in becoming more aware of the differences between healthy and unhealthy ways of managing anger.

The latter part of the group cycle was consistent with the goals of Stage 3, reconnection (Herman, 1992). In this stage, survivors redefine themselves in the light of their traumatic experiences, place these experiences in the broader perspective of their total life story, and reinvest in life and the future. This includes forming new relationships and reintegrating into the community. Reclamation of a sense of dignity and value is a fundamental task of this stage.

One of the themes typically explored in this stage was referred to as "strengths and resources" or "stories of survival." We hoped to support clients in developing a more positive self-image, namely, as survivors rather than victims and as persons who had shown courage and a capacity to endure. We hoped to enhance their awareness of coping strategies they had used in the past and might therefore use in the future, to contribute to the restoration of a capacity to trust other human beings by remembering that others had played a role in their survival, and to help group members learn to recognize and validate each other's strengths.

A variety of techniques were used to accomplish these goals. In some groups, the facilitator would tell a folktale about a protagonist who had endured terrible hardships by a combination of ingenuity and determination, and clients would comment on the lessons conveyed in the story. Clients would then share their own stories, considering questions such as, What qualities in yourself did you draw on when things became especially hard? Sometimes clients would portray their story in a drawing and then share their story through the drawing.

During the last part of the group cycle, we also drew on the healing power of images. A technique that was consistently well-received was the use of a poster-size painting of a tree that had lost many of its branches and leaves but was still standing, possessed strong roots, and showed signs of inchoate life (e.g., buds or a few tiny flowers). This poster was used as a catalyst for exploring themes of loss and renewal and clients' inherent dignity and value as human beings. In response to the poster and discussion, clients would usually arrive at the idea that even when a tree has lost most of its branches and leaves, if it still has roots, the inner core of a tree, and a capacity

to grow and to produce new blossoms, then it is still a tree. They would relate this idea to themselves, often culminating in a discussion about a person's indestructible core or soul, sometimes leading to a guided visualization in which they would try to receive a message from their inner core.

Survivors of torture and war trauma tend to be very preoccupied with the past. This trauma-related difficulty with envisioning or planning for the future was exacerbated by the overwhelming challenges of daily survival in the camps. Thus, in the last part of the group cycle, another theme we sought to explore was facing the future. Through a combination of discussion and creative techniques (e.g., inviting clients to perform a pantomime of something they hoped to do in the future and having others guess what they were pantomiming; drawing a ladder to the stars and listing within each rung a small step required for the accomplishment of a larger goal), we attempted to help clients generate realistic goals, begin to prepare for future challenges, and think about ways to rebuild their lives.

Very often, in preparation for the final session, clients would express a desire to perform some type of ritual signifying their completion of the cycle. We felt that in many instances, rituals could contribute to the work of Stage 3, reinvesting in life. The clients had many creative ideas for ways to acknowledge the ending of their group experience. These included the following: sharing favorite cultural stories, proverbs, poems, or songs; planting a palm tree or a flower garden together near the counseling hut (one group planted the flowers in the shape of a circle, with each flower representing one group member); taking a group photo and then having group members make cardboard frames for holding the photos; bringing scraps of material, needles, and thread and using them to sew something special together (in one group, participants sewed a cat to represent having seven lives and, therefore, their own capacity to survive); and building a miniature wooden boat in which group members placed messages expressing their wishes and dreams for the future and which they then released on the river in the direction of their home country.

A ritual that was often used in the final session of a cycle was to invite the clients to go outside and find an object that symbolized hope and healing. Clients would then take turns showing the object and explaining how and why they had chosen it. For example, one client would present a stone and say that it represented indestructibility. Another would present a green leaf and say that it represented the possibility of new life, and so forth. Clients tended to be very moved and engaged during this process.

The most common closing ritual was to share a simple meal together at the end of the final session. Among our

clients, it was commonly believed that once people have partaken of food together, they will never injure or betray one another in the future. In many groups, when members shared a meal in the final session, they also set aside a portion in memory of their lost loved ones. Sharing a meal was also a way of expressing feelings of connection and mutual respect among group members, as well as a means by which facilitators could express their recognition of the courage and commitment that the clients had shown by remaining with the group for the duration of the cycle.

After a group cycle was over, clients usually continued to stay in touch with each other, often becoming significant sources of both emotional sustenance and practical assistance for one another. Many former clients showed an interest in building greater community awareness about torture and war trauma. This interest seemed consistent with the goals of the last stage of recovery from torture and war trauma, in which an important component is regaining the capacity for meaningful participation in public life. Often, this also involves a desire to help other survivors and to be part of collective efforts at prevention, awareness, justice, political transformation, and truth telling.

A powerful example of the ways that public truth telling can both indicate and contribute to trauma healing occurred each year on June 26th, the United Nations International Day in Support of Victims of Torture.² At CVT-Guinea, we viewed June 26th primarily as an opportunity to raise awareness about torture. At the same time, the day served as a venue in which CVT clients and former clients could give voice, in a public setting, to their experiences of torture and war.

One example of this was a group of teenage clients who took part in a collaborative poem-making exercise, in which each person wrote one line that conveyed the essence of his or her experience of having been tortured. With facilitation, these lines were then combined to form a group poem that expressed core aspects of the clients' experiences, without identifying which individual had written which line. Two of the teenagers—one male and one female—expressed a desire to read the group poem aloud for the wider camp community. These presenters, their peers who had shared in the writing, as well as the audience all seemed invigorated and inspired.

Another example of a creative means of bearing witness to experiences of torture and war was the memory cloth and Liberian timeline, adapted from the Trauma Centre for Survivors of Violence and Torture in Cape Town, South Africa. The method had conceptual roots in narrative approaches, which emphasize the importance of being able to think of events in a coherent sequence. Participants were first invited to collaboratively recall key political events from the beginning of the unrest to the

present. These events were written on a timeline of modern Liberian history, beginning with the 1980 rice riots that preceded the first coup. Participants were then provided with square pieces of fabric of various colors and were asked to think of a loved one who was tortured and/or killed and to write on the cloth the person's name and the date, place, and manner in which he or she was victimized. Next, with the empathic support of the facilitators, each person was invited to share his or her story with the other participants. Finally, each person placed his or her loved one's square on the timeline cloth, matching private tragedy to the corresponding political event, thereby peopling the history. For many participants, this was the first time that they had ever linked their personal stories to a larger historical and political context, thereby becoming better able to make sense of traumatic experiences that had previously seemed entirely incomprehensible. The cloth functioned as a container that allowed the survivor to stand outside the story and bear witness to it, rather than being imprisoned by it, and also served as a physical space in which survivors could both memorialize loved ones who were killed and acknowledge those who survived.

Moreover, there soon emerged, beyond the images of the tragic losses of specific beloved individuals, a powerful representation of massive collective losses that had resulted from repeated, large-scale civil wars. Thus, pain that had seemed purely personal was discovered to be part of the larger, collective phenomenon of ethnopolitical persecution and war. We believe that this realization can contribute to reconnection with the community, thereby deepening the work of the last stage of healing.

Program Evaluation

Throughout the duration of the program, PSAs were trained and supervised in conducting psychosocial assessments and in using assessment to inform treatment. Intake assessments included demographic information; trauma history; rating scales for symptoms of depression, anxiety, posttraumatic stress, and somatic complaints; and measures of social support, interpersonal relationships, and ability to engage in important daily activities (e.g., house-keeping, income generation, recreation). Back-translation between English and several ethnic languages helped to ensure that the measures were culturally appropriate. The measures of psychological symptoms, social support, and daily functioning were re-administered at 1 month, 3 months, 6 months, and 12 months after intake. Statistical analyses of the data consistently showed both significant

² The *Convention Against Torture* (United Nations General Assembly, 1984) came into force on June 26, 1987. Ten years later, the United Nations General Assembly proclaimed June 26th as the United Nations International Day in Support of Victims of Torture.

and meaningful reductions in trauma symptoms and increases in social support and daily functioning during and after participation in group therapy.

In addition to these quantitative measures, there were numerous instances in which clients of all ages and backgrounds verbally expressed appreciation for the assistance they had received from CVT. Although these testimonials occurred frequently throughout the duration of the program, a particularly powerful example occurred at the end of March 2005, when CVT held its closing ceremony in the camps. As part of this ceremony, the PSAs and program staff began to march through the camps, with an open invitation that anyone who felt that he or she had benefited from CVT's services could join in. Hundreds of men, women, teenagers, and children ran from all over the camps to participate in the march. Together, a massive crowd of united survivors of torture and war trauma, along with those who had served them for the preceding five years, reached the area of the camp where a Speak-Out was scheduled. Microphones and benches were provided, and for several hours, person after person, of varying ages, both genders, and from diverse ethnic backgrounds, spoke to a large gathering of community members about what the work of CVT had meant to them and about their own experiences of trauma and recovery. These brave souls overcame feelings of shame, isolation, and stigmatization in order to speak their truths. Thus they discovered that they were not alone, but were among the thousands of survivors of torture and war all over the world who are working to rebuild their lives and communities.

Author's Note

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Shanee Stepakoff is now with the United Nations-backed war crimes tribunal (Special Court) in Freetown, Sierra Leone. Jon Hubbard is now with CVT headquarters (Minneapolis, Minnesota). Maki Katoh and Yuvenalis Omagwa are now with CVT-Sierra Leone (Freetown, Sierra Leone). Erika Falk is now with Survivors International (San Francisco, California). Jean-Baptiste Mikulu is now with CVT-Liberia (Monrovia, Liberia). Potiphar Nkhoma now divides his time between Cape Town, South Africa, and Savannah, Georgia.

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