Rebuilding Communities

Training trauma survivors to help communities heal after atrocities

by Binta Barry & Nancy L. Pearson

NEW Tactics in Human Rights

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I want to thank CVT for sending me to participate in the New Tactics in Human Rights workshop. I learned a lot from the workshop which has motivated me to explore different human right violations, understanding how I can double my learning capacity to address some of these issues in my country. In my country, Sierra Leone, we don't have the opportunity to do these courses at university level and my dreams are to see myself in one of the universities studying in the psychology department.
— Binta "Neneh" Barry

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— Nancy L. Pearson, M.S.W., L.I.S.W.

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Binta Barry & Nancy L. Pearson

Binta Barry, affectionately called "Neneh" (mother) at just 25 years old, is a member of the Fullah tribe and was born in the Kono district of Koidu Town, Sierra Leone. She attended primary school in Kono, completed high school in Freetown, and sat for her O-level college entrance exams in 1997. While Binta had hoped to study medicine in the West and return later to her country to help her people, a rebel attack in 1997 forced her to flee to Guinea to escape the war raging in Sierra Leone. She was among the first refugees to receive training through the Center for Victims of Torture Refugee Mental Health Project and steadily gained skills and competence. In her fourth year with CVT, she became a training supervisor for other refugee mental health specialists and the international Special Court for Sierra Leone recently hired her as a psychosocial counselor. Working with a psychologist, she provides psychological and social assistance before, during and after trial to those who will be testifying about human rights abuses. She also provides training to protection officers and connects witnesses to other service organizations.

Nancy L. Pearson, M.S.W., L.I.S.W., joined the CVT staff in April 1999 as a direct-service social worker, working with clients and trainers of Minnesota-based social service providers. She became the director of social services training in September 2000, providing training for CVT's state, national and international programs. Nancy was part of the initial team of trainers for the psychosocial agents in Guinea, providing training to two groups of 40 specialists in 2000 and 2001. She is currently the training manager of the New Tactics in Human Rights project. She received her bachelor of science in social work and sociology from Augsburg College in Minneapolis, Minnesota and her master's in social welfare from the University of California, Berkeley.

September 2004

Dear Friend,

Welcome to the New Tactics in Human Rights Tactical Notebook Series! In each notebook a human rights practitioner describes an innovative tactic that was used successfully in advancing human rights. The authors are part of the broad and diverse human rights movement including nongovernment and government perspectives, educators, law enforcement personnel, truth and reconciliation processes, women's rights and mental health advocates. They have both adapted and pioneered tactics that have contributed to human rights in their home countries. In addition, they have utilized tactics that when adapted can be applied in other countries and other situations to address a variety of issues.

Each notebook contains detailed information on *how* the author and his or her organization achieved what they did. We want to inspire other human rights practitioners to think *tactically*—and to broaden the realm of tactics considered to effectively advance human rights.

In this notebook, we learn about building local and long-term capacity building within communities to address massive human rights atrocities. The Center for Victims of Torture has instituted an intensive training and supervision model for refugees to develop local capacity for providing understanding and skills for mental health support to rebuild communities after massive human rights atrocities. CVT has instituted the training model in refugee camps in Guinea and Sierra Leone for refugees from Sierra Leone and Liberia. The model combines intensive, hands-on training of refugees with ongoing supervision. These refugee "mental health specialists" build their capabilities, provide individual and group therapy for traumatized individuals and use their skills toward rebuilding their own communities and support systems. There are currently 122 "mental health specialists" involved in this ongoing training and supervision model with thousands of refugees of all ages having received a wide variety of services. Devastating wars in every region of world have created massive number of refugees and internally displaced people who have witnessed or been victims of horrible human rights atrocities. This notebook may provide tactical ideas to those assisting these communities trying to rebuild their lives.

The entire series of Tactical Notebooks is available online at www.newtactics.org. Additional notebooks will continue to be added over time. On our web site you will also find other tools, including a searchable database of tactics, a discussion forum for human rights practitioners and information about our workshops and symposium. To subscribe to the New Tactics newsletter, please send an e-mail to newtactics@cvt.org.

The New Tactics in Human Rights Project is an international initiative led by a diverse group of organizations and practitioners from around the world. The project is coordinated by the Center for Victims of Torture and grew out of our experiences as a creator of new tactics and as a treatment center that also advocates for the protection of human rights from a unique position—one of healing and reclaiming civic leadership.

We hope that you will find these notebooks informational and thought-provoking.

Sincerely,

Kate Kelsch

Kate Kelsch

New Tactics Project Manager

Introduction

AN OVERWHELMING NEED

Even as the world has witnessed substantial gains in the development of international mechanisms to monitor human rights violations and prosecute offenders, mass atrocities continue to plague many countries, including Sierra Leone. The nation's people endured more than a decade of civil war, suffering brutality and massive rights violations aimed at ripping apart the social fabric, undermining cultural and family values and destroying community leadership and structures.

Sierra Leone, a country of approximately six million people, is composed of 20 tribes following a variety of faiths—Muslim, indigenous and Christian. The country gained independence from Great Britain in 1961. Despite rich mineral and human resources, by 1990 Sierra Leone had one of the most skewed income distributions, with 82 percent of the population living below the poverty line.[1]

An eleven-year civil war provoked in 1991 by the Revolutionary United Front resulted in tens of thousands of deaths and the displacement of over one-third of the population. The conflict caused more than 450,000 people to flee to neighboring countries—mainly Guinea and Liberia—and left an estimated one million people internally displaced within the country. With the RUF conducting systematic and brutal assaults on the civilian population, survivors had witnessed or survived brutal atrocities[2] including mutilations, amputations, forced recruitment of children and adults as soldiers, forced labor and horrendous sexual crimes. International observers described the situation: "The rebels sought to dominate women and their communities by deliberately undermining cultural values and community relationships, destroying the ties that hold society together. Child combatants raped women who were old enough to be their grandmothers, rebels raped pregnant and breastfeeding mothers and fathers were forced to watch their daughters being raped."[3] Girls as young as seven or eight were used as sex slaves.

At the time the Center for Victims of Torture was launching its program in Guinea, there were more than 300,000 Sierra Leonean refugees and more than 120,000 Liberian refugees in the country.[4] Conservatively estimating that 5 to 10 percent of the refugee population could benefit from mental health interventions and needed more than social opportunities or skills training to regain their life functioning, 20,000 to 40,000 people were in need of such assistance.

Sierra Leonean communities were broken apart by the atrocities of the war. And many of the individuals who endured and survived such atrocities remembered their experiences in silence.

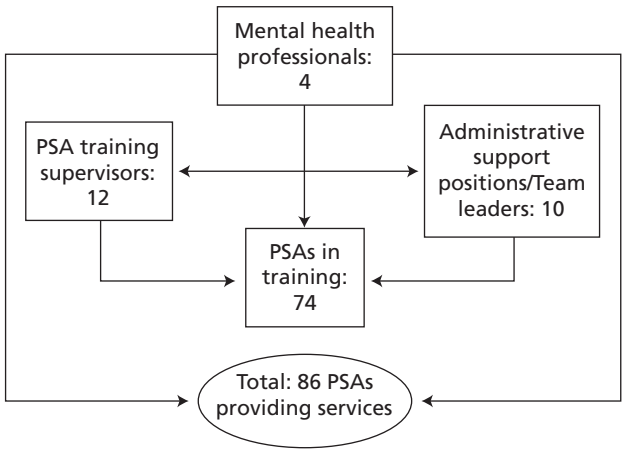
RESPONDING TO THE NEED

CVT set out to respond to the overwhelming needs of a refugee population that had suffered massive atrocities and violence.

Since 1985, CVT has been helping survivors of politically motivated torture from more than 60 countries heal and rebuild their lives. We have long recognized that the majority of torture[5] survivors, as well as survivors of war trauma,[6] are unable to access rehabilitation services even if they do reach resettlement countries. Generally, they remain in refugee camps or displaced within their home country without ever receiving assistance. While most, given a supportive environment and an opportunity to be productive, are able to regain meaning and purpose and rebuild their lives without assistance or mental health interventions, there is still a small but significant number who need help to regain their resiliency. CVT had been seeking ways to reach this population.

In 1999, CVT responded to the opportunity to provide mental health services for refugees living in the camps surrounding Guéckédou, Guinea, known as the Parrot's Beak region. Through interviews, observations and expressions of need from refugees and NGOs working in the area, CVT recognized the critical need for these services. It was clear, however, that there was a greater need for services than an organization of this size and capacity could provide.[7] As one ob-

Structure of the CVT Refugee Mental Health Project in Sierra Leone
January to December, 2003



server note, "For every person directly victimized, there were 30 others who witnessed the atrocity or were made to actually perpetrate it."[8]

Psychosocial agents in Boreah, Guinea. Binta Barry is third from left in the top row. Courtesy of Linneke Sassen

The tactic presented in this notebook was developed for use in a post-conflict refugee setting with no mental health resources. Its core components are intensive training and supervision, both used to build the capacity among refugees to provide mental health services within their own communities by serving as peer counselors (referred to in the project as psychosocial agents, or PSAs). The training and supervision offer "hands-on" experience to these peer counselors while providing high-quality services to the target population—those in need of mental health services. They combine practical experience with classroom[9] training, monitoring and follow-up. In addition to providing much-needed mental health services, the peer counselors are a tremendous legacy. If CVT should have to leave the region, these peer counselors will remain, serving as significant resources in their communities.

CVT's long-term goal in West Africa is to build awareness of torture and of mental health issues, at the same time providing a corps of paraprofessionals with the skills to deal with many of the mental health problems that exist in a post-war setting. CVT began the project foreseeing that the participation of professional mental health staff on the ground would eventually be phased out and that a trained, cost-effective paraprofessional corps would be in place for use by government institutions or other nongovernmental organizations and bodies.

Training peer counselors can be a controversial and difficult choice for mental health professionals. The medical profession's oath to "do no harm" creates a burden of responsibility that many choose not to accept. CVT created this intensive training and supervision model both to meet both our responsibility to "do no harm" and to fill the overwhelming demand from individuals and communities seeking to rebuild their lives following atrocities and violence.

Rarely can traditional healing methods adequately address mass atrocities and community violence, so far outside of normal life experience. Even in countries where mental health professionals are available to provide services, the consequences of mass horror are likely to overwhelm existing mental health systems. And when help is available, the people most in need may be unable to access it. They may fear being targeted or arrested if they come forward; they may worry about being labeled as "crazy" by their family or community; they may fear being stigmatized if they reveal that they have been raped, that they are HIV-positive, or that they have been forced to perpetrate violence on others. They may face other barriers as well: cultural ones such as language, religion or ethnic and tribal differences or discrimination; or financial and logistical ones such as an inability to afford counseling sessions or to find transportation to those sessions.

Our intensive training and supervision model requires the commitment of substantial resources in the earlier years, decreasing, albeit with increasingly positive results, as time goes on. CVT's local logistical and administrative staff also becomes increasingly qualified to take over tasks of organization and management. The model has been well received by the target population—those in need of assistance—in the refugee and repatriated communities.

Initially, trained professionals provide services while refugee trainees study psychological concepts and observe their practical application. Under direct supervision, trainees then begin providing the services themselves. Once the PSAs are adequately prepared, they are able to take on greater responsibilities, and begin to conduct counseling sessions under limited supervision by the professional staff. They also receive more intensive training on a rotating basis, working side-by-side with the professional staff to gain additional experience with a range of clients, issues and problems. The most promising trainees eventually take on the same responsibilities as the professional

staff, including the supervision of other PSAs. CVT currently has over 120 PSAs in training in West Africa (86 in Sierra Leone and 42 in Guinea) and plans to expand this group in the coming years. This small cadre of PSAs provides a wide variety of services to thousands of people.

CVT's experience of creating, instituting and continually adapting this intensive training and supervision model may provide insights to others seeking to address the overwhelming needs of communities ravaged by massive atrocities and widespread violence.

Tactic development: Empowering survivors to become healers

Prior to setting up the program in Guinea, CVT conducted an initial survey of mental health needs in the Guéckédou region in the summer 1999. This survey included discussions with United Nations agencies and NGOs already working in the camps, meetings with refugee camp leaders to discuss the problems facing refugees, observations of refugees and discussions with them about their needs and how they were trying to meet those needs. We explored local capacity in relation to medical and mental health services and the ways in which traditional healers were able to respond to the traumas experienced by their community members. We also reviewed the predominant models used for mental health interventions in similar situations.

WHY TRAIN REFUGEES AS PEER COUNSELORS?

Our staff and resources were far too limited to meet the needs of the numerous people who could benefit from mental health services. And while an effort to assist the healing and rebuilding of these communities requires long-term commitment, we recognized that we could not guarantee our presence. Funding commitments to such programs are hard-won and, in addition, even as we were developing the program, severe instability in the region continued to be the norm.

The design and implementation of the tactic was born from a strategic decision in which we acknowledged the practical constraints of human and material resources and decided on a goal of creating a local capacity to competently serve the community's mental health needs. Our chosen vehicle was a model of intensive refugee psychosocial training and supervision, used to develop this long-term capacity while also providing immediate mental health services.

How does the tactic work?

Psychosocial agents are selected from the refugee community itself and provide services to their community through a hands-on training process with experienced mental health professionals.

> When it comes to trauma, many times people will tell you, "They killed my Ma, they killed my Pa in the gross way. I'm a Christian, or I'm a Muslim, I keep praying to God that everything will go." Although it's hurting them, they are getting drugs, they are losing weight, they are not able to sleep. They have lots of problems. They have this anger problem in the communities and in the families. But whenever you approach them, they will tell you, "Well, it has already happened." And you find that you cannot blame them, because even myself, I didn't know that there was any treatment for trauma. All I felt was, when you are not able to sleep, you can take some pills or people can take wine or liquor and sleep. So people have been carrying their problems to the clinic, where they will go say, "Doctor, I can't sleep," and they give them medicine to sleep. "Doctor, I can't eat," and they give them vitamins to have an appetite. Now we join the CVT family and we have been talking to them, because we are all country people, and we talk to them in their local dialects and we are able to understand what is happening to them. But some, they say, "Oh! Maybe my Ma's spirit's behind me or my father's spirit's behind me" and this is why this is happening. They have never recognized it as trauma. But now we've been able to sensitize these people to know that these things happening are not mother's spirit behind you, it's not your grandfather's spirit, it is the trauma that is affecting you.
>
> *Liberian psychosocial agent*
>
> The training I received from CVT clinicians is actually guiding me to respond to some of the psychological needs in my community. Most women are coming to me for assistance and they trust me, they share their feelings with me in order for me to give some emotional support. It is challenging for me, but I am willing to go further with this as I have planned to help women in my community. I definitely want to continue to work in this field of psychology; I would try my best to see that I become an expert. I have seen that my community is benefiting, so it is a challenge for me. This has brought so many changes in my personal life, my family and also my community.
>
> *Binta Barry, Sierra Leonean psychosocial agent*

SETTING UP THE STRUCTURE

This notebook will not detail all aspects of developing a community-based project. In any such project, however, it is essential to build support, understanding and trust within the community. Without that support, an intensive training and supervision model of this sort may not be possible.

Recovery from the kind of atrocities experienced by the people of Sierra Leone takes time. Because there was no existing treatment center or professional staff available to provide services, we needed a long-range and long-term commitment in order to develop this capacity within the community. Simply setting up the structure for the training and supervision model required a number of components to be put in place.

Recruitment, for example, is a first and essential step in maintaining a professional mental health staff to provide training and supervision until the PSAs can demonstrate their capacity to maintain the program and provide services on their own. This recruitment has been an ongoing challenge for us. It was crucial to seek people with a base of experience in the field of severe trauma. It would have been optimal, in addition, to recruit these professionals from within the refugee community, but this was not possible in the camps in Guinea and Sierra Leone. The staff have instead come from many countries—Australia, Chile, the Democratic Republic of Congo, France, Kenya, Nepal, the Netherlands, the Philippines, Rwanda, Singapore, South Africa, Spain, Uganda, the United Kingdom and the United States—and have varied professional backgrounds such as psychology, social work, psychiatry and psychiatric nursing. While their diversity has deeply enriched the project, the varied perspectives and conceptual approaches they bring have created challenges. Difficulties in communication and consistency can be confusing for PSAs learning such new skills and having to adjust to new supervisors with their own styles and backgrounds. We take particular care to maintain a standardized training curriculum and ensure consistency in the basic training information for the PSAs, even while preserving freedom for the professional staff to contribute their areas of expertise and incorporate their various supervisory styles.

It's important to go beyond the résumé to give a small written academic skills exam. Résumés aren't always put together by the persons themselves. A subset of applicants were given an individual oral interview, followed by the group interview exercise where they were given a case study and told to discuss how to handle the situation. Later some community leaders in the camp situation advised CVT to try to represent the various ethnic groups in hiring as well, and this was honored. In choosing PSAs, CVT has found that those who were already in some kind of helping profession, like nursing or teaching, or volunteers in their religious organizations, became better PSAs.

Michael Kariuki Kamau, professional staff from Kenya

I accompanied the clinicians [the professional staff] to observe how they facilitate different groups and to also practice what I learned in theory. I benefited a lot from observing how the groups were going on. This is how I started until I became more confident in facilitating groups with the supervision of the clinicians. And I was later promoted as a program assistant, in order to be going round with the clinicians to facilitate groups. I found out that my people were interested in the program. They actually benefited from the services CVT was rendering to the refugees.

Binta Barry, Sierra Leonean psychosocial agent

I started to love the nursing field. So I had in mind to be a nurse. I went for my first course. I started attending the university the first semester. I had in mind to do nursing up to the time war came. So I only did one semester and then I put it on the side. As soon as I came here as a refugee, at least I had the opportunity to come and start to work with CVT. So I'm very happy. Even if I become a nurse, a nurse is also a counselor—you have to know how to talk to people, how to become a good nurse. But if I have the opportunity now to go to a nursing school or I can have the opportunity to become a trained counselor and then I have a further training, I would really appreciate it, because I like the field, I enjoy it so much.

Liberian psychosocial agent

The next step involves the creation of the training and supervision model. Our goal was to create a program that could blend lessons from Western psychotherapy with local wisdom about trauma and recovery. The model is built around the supervision of hands-on training and skill-building opportunities derived from participation in actual mental health services; these services include general referrals, individual casework, small groups, community-wide activities and interventions that incorporate the trainees' cultural knowledge.

Finally, we established a recruitment process to find refugees ready and willing to make a long-term commitment to their community and to building their psychosocial skills through intensive, ongoing training and supervision. The remainder of this notebook focuses on this process of recruiting, training and supervising refugee peer counselors.

RECRUITING & SELECTING PEER COUNSELORS

The first application process for PSAs drew more than 200 applicants for 40 positions. This was not surprising, given that there are so few opportunities for refugees to find productive work. We needed to develop a process that could identify people who had a genuine desire to help their fellow refugees, an open mind to learn and behaviors and manners that would encourage members of the community to seek their assistance.

The process includes an initial written application, with a possible follow-up oral interview, a case study written test, a group interview experience and participation in an initial group training of five to seven days.

Applications

In the refugee camps where the CVT Refugee Mental Health Project seeks to provide services, a notice is posted requesting people to apply for the position of psychosocial agents. Applicants submit a letter of application and a résumé.

Given that the majority of refugees are women and children, CVT has sought ways to ensure that women

Excerpts from written test for applicants for CVT Psychosocial Agent position

Note: The following excerpts and sample questions have been used to help CVT gain insights into each applicant's views about issues that refugees may face. Answers may indicate applicants' willingness to discuss these issues, their ideas about maintaining the confidentiality of what has been shared and their ability to explore options or viewpoints that might differ from their own. Those with very rigid ideas about how people should feel and behave do not make the best candidates for becoming peer counselors.

Dear Candidate,
Be aware that the counselor in this case (a man in this example) does not necessarily act as a professionally trained counselor and can be improved in what he does. In the questions about the case you will have the opportunity to give your ideas about good counseling.

The numbers in the text refer to the actions of the counselor, which you will be asked about later.

A young woman of 17 years, called Fatmata, comes to the counselor to complain about headaches and stomach pains. The counselor refers her to the health clinic (1), but the client says she has been there already. She is hesitant to tell about the result of the medical consultation.

The counselor then asks the woman if she has other problems (2). After much hesitation and silence, Fatmata tells about her fear of being pregnant. She doesn't want to be pregnant, she says. The counselor asks why she doesn't want to be pregnant (3), but Fatmata has great difficulty in telling this, she evidently doesn't really dare to come out with it. The counselor proceeds saying that it is difficult to help her if she doesn't tell what he needs to know (4).

The counselor asks who the father is (5). Fatmata doesn't want to say at first, but finally agrees to tell if the counselor will not tell it to anyone. The counselor refuses to do this (6) saying that it may be his task to go to the father and tell him his responsibility.

Sample Questions
1. After Fatmata has presented her complaints, the counselor immediately refers her to the clinic (see 1). Would you have done the same as the counselor? Please explain.

2. Do you think Fatmata was unwilling to be counseled? Please explain your opinion.

3. Fatmata says she's afraid to be pregnant, but is not willing to tell why. The counselor reacts by saying that she has to tell everything in order for the counselor to help her (see 4). Do you agree with the counselor that a client should tell everything in order to be helped? Please explain your answer.

4. The counselor asks who the father is (5) and does not accept the client's wish to keep it secret (6). Would you have done the same in this situation? Please explain your answer.

5. The counselor advises Fatmata to go to the father and tell him his responsibility. What do you think Fatmata will do? Will she do what the counselor advises? What other options may she have? What do you think of this advice? Would you have given the same advice?

6. Fatmata came with certain expectations to the counselor. What do you think is the feeling of Fatmata after this counseling session? Would she feel content with it? What is it she may have expected when she decided to go see the counselor?

have the opportunity to become PSAs.[10] We have also worked to ensure representation of the ethnic groups in the refugee camps where we offer services.

Case study written test
People can generally identify those they think are doing well in their community and those who are not, even though they may not talk about this in terms of mental health.[11] We wanted to give applicants an example they could relate to and in doing so provide ourselves with an opportunity to evaluate how applicants perceive and respond to such a situation. The same case study example is also used during the group interview process and in the initial training period, to help new PSAs understand basic areas of skill development required for becoming competent counselors in their communities.

Applicants take a written test describing the actions of a counselor and a client during an actual case, and we have developed a general rating system to assess the applicants' ability to convey their reactions. We are interested to know how these answers might reflect upon their tendencies toward empathy for another's situation and openness for exploring alternatives without critical judgment of another person and his or her situation. If there are significant discrepancies among the raters, the raters discuss their rationales until an agreement can be reached. This is particularly important given our desire to include applicants who may not be proficient in English.

Group interview
Based upon the written application letters and résumés, the written tests and considerations of gender and ethnic composition, certain applicants are selected to participate in a group interview. This was initially done by the expatriate staff. As PSAs have gained experience and been promoted to positions with additional responsibilities, they have been included in the process of selecting new candidates.

Candidates are then placed in groups of five to six people and asked to discuss a specific topic while the professional staff and experienced PSAs observe their group process. We learned from trial and error that it is helpful to use a case study to stimulate discussion and obtain a better sense of the applicants and their communication styles and openness. The observation focuses on verbal and nonverbal behaviors, group management, participation in the discussion and the ability of applicants to relate to other group members, including those of the opposite sex.

Applicants are rated according to these areas, with consideration given to group dynamics. We are not expecting candidates to arrive with skills in group management or counseling. Rather, we are seeking to observe natural tendencies and behaviors. We have found, for example, that those who constantly attempt to dominate discussions, give directives or advice to other members of the group, or consistently ignore or belittle other group members are not the best candidates for training.

These situations provide staff with an excellent opportunity to observe. If one participant is trying to dominate the entire discussion, how do other members of the group attempt to intervene or steer the participant toward including others? If a participant is disregarding or belittling the opinion of a woman participant, how do other members react or try to include her? This group experience becomes a concrete example with which chosen candidates begin to learn about group dynamics and is revisited during the ongoing training process.

I am a Sierra Leonean refugee aged 27, living in Guinea since 1991. CVT hired me last year to work and serve fellow refugees from Liberia and Sierra Leone living here in Guinea. I initially had no idea about the work. CVT began to train me in various skills, concepts, principles and approaches. I work with the adult males and training is ongoing. This training has enabled me to successfully treat a man who was isolated and wanted to end his own life because of bitter experiences he faced in the war. After some time of my interactions with him, he has now adopted positive coping styles and is hopeful for his future.

Guinean psychosocial agent

It was made particularly apparent to me how staff is benefiting from training when I did training on posttraumatic stress symptoms. As we went through each category, I asked the staff if they had known anyone or experienced any of the symptoms. I was amazed with the examples they offered from their own life and how they nodded in agreement when one person spoke about their experiences. When I finished the symptom list, one of the PSAs exclaimed, "You have just described us!" While there was a certain sadness in the room from the remembering and sharing of past experiences, there was also a feeling of excitement. I had this sense from the PSAs that they understood not only what had been happening with their own mental health, but also that were beginning to understand that this was a normal reaction and one that was shared by their colleagues. And, of course, by understanding their own experiences and reactions, I believe this has helped them to be better workers in the field.

Alison Beckman, social worker, supervisor in Guinea

We are operating in several villages. In all these areas are villagers who've suffered from the brutal war. We go into the community. We sensitize people. They have these problems and you can even identify them by looking at them. So when we identify them, sometimes we put them into groups for group counseling. There are some cases that are dealt with individually, individual counseling. We also conduct family counseling when necessary, and we also provide sometimes a little after-care for them, after going through the counseling cycle. We are supervised here by one clinician, conducting training for PSAs and in turn these PSAs go to implement this to their people.

Sierra Leonean psychosocial agent

INITIAL TRAINING PERIOD

Selected candidates participate in an initial training session; five to seven days in length, and with anywhere from 20 to 45 participants, this training takes place outside of the refugee camp to help the candidates bond as a team while they begin learning the basic skills they will use immediately upon accepting their PSA position.

Our first approaches to this initial training period taught us important lessons. At first, for instance, the training period lasted two weeks. We found that we were including too much information to fully digest and incorporate in such a short time and thus adjusted this initial training to focus on two central elements: an introduction to the overall mission and goals of the CVT Refugee Mental Health Project and the building of skills that the new PSAs would need to begin upon their return to the camps.

The bulk of the initial training is dedicated to the collective exploration of concepts in mental health and of coping styles used to deal with life stresses. These discussions are informative to both the new PSAs and the professional staff. Subjects include:

- How the effects of war and torture have manifested in individuals, families and communities.
- How the PSAs themselves and their communities describe the physical, psychological and social effects of trauma. Although they may not use clinical terms (depression, anxiety, posttraumatic stress disorder, social withdrawal), they do describe these general and pervasive symptoms. This is an important part of the process for the professional staff, who learn the perceptions of the refugees and the terms used within the community to describe these behaviors. The professional staff are

Boreah, Guinea, women's department. Courtesy of Linneke Sassen.

Topics covered in initial training

Outline of topics covered in the didactic segment of training for new psychosocial agents:

- Introduction to CVT and the CVT Refugee Mental Health Project.
- Role of the PSA.
- Competencies required for the PSA job.
- Duties of a PSA, in detail.
- Impacts of war and torture.
- How to identify survivors of torture and war trauma.
- How to sensitize the community to the effects of war.
- How to observe and interpret behavior.
- How to build basic counseling and interpreting techniques.

thus better able to relate to both PSAs and members of the community as they work to show how these behaviors may be coping mechanisms or reactions to traumatic experiences. Such discussions also provide clues for identifying strengths and pathways to healing.

- Skills training, which highlights the skills and concepts the PSAs will need as they begin their work. These include understanding confidentiality and the rationale behind it, active listening, ways of offering support, collaborative problem-solving and basic skills in being and using an interpreter.

PSAs don't "graduate" from training and supervision. They continue to receive individual training and supervision in:

- the fundamentals and development of communication and counseling;
- awareness, identification, assessment, treatment and rehabilitation of trauma victims;
- integration of social and community activities for the targeted population facing difficulties coping with the past, present and future; and
- Client assessment and follow-up (every one, three, six and 12 months).

PSA ROLES &
ONGOING TRAINING & SUPERVISION

In refugee settings in Guinea and in towns and communities in Sierra Leone, CVT continues to develop focused information campaigns for trauma and mental health awareness. Our experiences both inside and outside of camp environments suggest that refugee communities are not only open to new mental health concepts but eagerly seek information about solutions to their psychological problems. CVT seeks to demystify the behaviors and emotional difficulties that result from trauma and to redefine these difficulties as issues of health instead of perceived external causes such as possession by witches and devils. CVT provides services to the most vulnerable among the population in the camps and communities where we operate.

We use a variety of techniques toward this aim. The interventions are designed to provide high-quality mental health and support services while PSAs are learning and building their skill capacities. For example:

- Individual counseling and family/home visitation are provided for all clients as part of the individual and group processes. Some may receive more extensive individualized attention; those who cannot immediately benefit from a group experience, for example, are helped individually until they build more self-confidence and rebuild or adapt their support systems. These efforts provide brief, solution-oriented counseling toward client empowerment.

- Small group counseling (groups of six to ten people) allows clients with similar problems to help and support each another emotionally by sharing problems and coping mechanisms. Depending on their problems, guidelines are prepared with topics for discussion and exploration. Groups meet for six to ten sessions. Clients are empowered to look at their problems in a different way, to resolve them or to integrate them into their lives in harmless ways while stabilizing their emotional lives. As a part of the small group experience, members visit each other between sessions to encourage and build social support once the group experience has been completed.

- Large-group and community interventions provide support to the counseling process and take a variety of forms: For issues including torture, war and mental health issues, we use community dialogue, mass education, dramatizations and role-playing and sensitization to the issues; there are also cultural activities, games, sports and the

therapeutic exercise of livelihood skills such as tailoring, needlework and hairdressing.

One indicator of PSAs' progress in training is that they are able to carry out these various roles in the project and community. A new PSA, for example, first participates in these activities by observing the professional staff and other more experienced PSAs performing these roles. The PSA continues to build skills by co-facilitating these activities with a professional staff member and works toward leading his or her own activities without direct supervision but with post-activity debriefing with professional staff. Senior PSAs continually improve their skills, using discussions with the supervisor to reflect upon the activities in a more in-depth manner.

Clearly, supervision by trained mental health professionals is essential to providing high-quality services and mental health interventions. The professional can ensure that PSAs develop the level of competency required to address client needs. As PSAs develop and demonstrate their skills in meeting these needs, the intensity of direct supervision can be reduced to maintain support while continuing to build the PSAs' confidence and competency. And as this competence grows, PSAs come to recognize counseling issues as they arise, understand the difficulty of dealing with such issues and realize they must continue to reflect upon each experience in order to learn and modify the methods used for healing.

PSA role: Community liaison in the sensitization process

PSAs play a major role in sensitizing the community to the impact of torture and war trauma on members of the community and to the benefits people can receive from the CVT program. PSAs conduct community outreach through dramatizations and role-playing, messages on T-shirts, door-to-door visits in the community and meetings with the refugee camp leaders; they also connect with international NGO and United Nations programs to set up communication and referrals to provide refugees with needed services.

PSA role: Peer counselor

Taking on the role of peer counselor is a step-by-step process. PSAs begin by assisting with large activity groups structured to provide therapeutic support to participating community members—for children, adolescents and adults. Most of the hands-on training and supervision then takes place within small therapeutic group settings, designed to help rebuild social supports for participants while providing an opportunity for PSAs to learn new skills. During the sessions, PSAs are given the opportunity first to observe and then to assist the professional staff in group facilitation until the staff determine they are ready to take over the facilitation of their own small groups and to meet with clients on their own as peer counselors.

The small group experiences help reduce social isolation, provide an opportunity to reconnect with others, and empower them to both receive and give social support. The experiences of torture and war coupled with the daily stresses of refugee camp life can push people further into isolation. PSAs provide an initial connection by visiting potential group members in their homes, then encouraging group participants to visit other members between sessions. PSAs meet with professional staff prior to and after each small group session to prepare for the small group process, then discuss how the process evolved and ideas for the session to come.

The training and supervision process provides an opportunity for the PSAs to explore their own experiences and how they cope with understanding the difficulties of others.

PSA role: Trainer

When PSAs have developed skills and capacity, they are also given the role of trainer for others—assisting in training new PSAs as well as in providing community trainings. When we have asked PSAs what makes a

> We made the community to understand that the signs and symptoms of war trauma are all normal to human life. Because you know you cannot forget about what you experienced, but we make it possible to live with the experiences that they have by way of processing. By that I mean that they will understand what they went through, what is happening to them or what symptoms are happening to them because they experienced certain things from their home before coming here. For instance, when we go in the community here to sensitize people, we are talking about these symptoms of war trauma, and you find people admitting, saying, "Oh yes, I can feel this way, I can feel that way. I don't sleep at night, I worry too much, I think too much about my people I left behind." So we try to normalize these feelings, related to war trauma and the bitter experiences people go through during conflict.
>
> *Liberian psychosocial agent*

> I enjoyed the group training. We work together and are able to brainstorm as to how to solve problems. When a client complains of lack of sleep, there was supervision on how to counsel a person to overcome that problem. I really enjoyed the supervision to help solve these problems. When it comes to the formal training, I have really benefited.
>
> *Liberian psychosocial agent*

> I have worked with many different clinicians and I have learned a lot from them all. I started chasing clinicians to teach me more, on how to handle different cases and also to go deep into communication skills, in order for me to be more skilled to help my people.
>
> *Binta Barry, Sierra Leonean psychosocial agent*

good trainer, they have responded that the essential qualities are the same for the mental health professional staff as for the PSAs themselves:

- respect for the area's cultural beliefs
- ability to assess PSA skills
- willingness to be supervised closely, including debriefing after every counseling session
- awareness of the differences between academic success and success in the field.

SUPERVISION

As each PSA's capacity is developed, more opportunities for leadership, training and supervision of others is encouraged and provided. The project's professional staff continue to provide ongoing supervision, training and support.

Dr. Athanase Hagengimana, professional staff from Rwanda, describes the supervision and the outcomes of the training: "I've arranged for PSAs to begin supervising others in the community who are directly training and counseling community members—such as Christian and Muslim religious leaders. After a session, the PSA debriefs with the leader, giving advice and feedback. This method has extended the influence of CVT to the majority of the community. The PSAs describe their influence on the Jembe camp as profound. People now know each other and talk with each other in the community, there is much less beating of children, and the PSAs are regularly called upon to solve problems and give advice on parenting in the community."

Impact & outcomes of the tactic

About 120 psychosocial agents have been trained, at different levels of capacity, since the beginning of the West African program in 1999. These PSAs, along with the mental health professionals, have provided direct service (individual counseling and small group therapy) to 5,000 clients. There have also been approximately 20,000 additional beneficiaries via community sensitization and large-group activities.

Our model was put to the test early when, in 2000 and 2001, rebel incursions into Guinea forced CVT's administrative and professional staff to evacuate a number of times. Ultimately, the Office of the United Nations High Commissioner for Refugees decided to relocate the entire refugee population residing in the Parrot's Beak region farther away from the border areas. Our model proved effective even this early in the program's implementation. The PSAs continued to work on their own during these periods of high uncertainty and provided critical support services to their communities—calming fears and organizing meetings to determine community and individual choices regarding the decision to relocate the refugee population.

> On the community level, community leaders are the first authority here over the camp population. There were a lot of things that the camp population did that were misconstrued by the community leaders. Based upon the training, it has come to our attention that most of these things that the community dwellers do are normal reactions to trauma. The community leader would look at it as being a misbehavior, where of course it is really normal for the person to behave in that way because of some things they underwent as they were running away from the war in Liberia. The community leaders were really behaving in the past out of ignorance. And so based upon the training, this has brought a very good effect on the community. The community leaders now understand that somebody behaving a certain way is the result of certain things he has experienced. That has been a very good impact, a significant impact.
>
> *Liberian psychosocial agent*

> I once was in a case wherein the client was faced with marital issues. She was having problems with the husband. The husband wanted to abandon her and take another wife. I had to do problem-solving constantly with this client. We were able to work on strategies and then focus at the point wherein the problem was solved. Now this client, she's really happy, the home is settled and she even promised that if she ever has any further problems she'll be willing to explain them to me. These are some of the activities that people here need in the communities.
>
> *Sierra Leonean psychosocial agent*

> What new personal capacity have I developed from the training? I can now be used to train other PSAs. There was a workshop that was held here and we, the PSAs, trained the community workers. So during that time I was able to train someone else who will be able to work in the community, who will be able to help others in the community. The objective of this training was that, when they go back, they should be able to sensitize their churches, their mosques and their communities about mental health.

While this tactic has made it possible for PSAs to provide much-needed services to refugees and to repatriated and reconstructing communities, it has also made a significant impact upon the PSAs themselves. The training and supervision received by the PSAs has often changed their own lives and that of their families in ways that can be both positive and challenging. Some have expressed a desire to continue in the field of mental health when they have the opportunity to return to their own communities.

The tactic provides the target populations with new ways to share and understand information about individual and social development that can give insights into past and present behaviors while offering opportunities for making different choices.

One additional outgrowth of the tactic has been CVT's dialogue with the Ministry of Health in Sierra Leone to encourage educational institutions to provide mental health training, especially in the area of trauma,

as they rebuild. CVT is also pursuing the possibility that PSAs could be tested and provided with a certificate or credentials that would validate their training and skills and that could be presented in professional settings beyond the project. Currently, for example, there is a proposal to combine the program of supervised field experience with weekend classroom work (12 hours per week), in partnership with the Department of Social Work, with the goal of awarding a one- or two-year degree in mental health counseling, perhaps combined with a recently initiated program for HIV/AIDS counseling. This is especially important as there is an insufficient mental health workforce in Sierra Leone and many other countries of Africa. The PSA cadres could help Sierra Leoneans and others returning home in post-conflict situations to deal with the psychological effects of torture or war trauma; with related issues such as traumatic grief and depression; with perpetrators and reintegration of child soldiers; and with other problems such as family conflict, domestic violence and child abuse, sexual assault and HIV/AIDS.

Funding such projects is an ongoing challenge. Resources continue to be available on a limited basis for refugee communities, but raising support for returnee communities has been very difficult. It is as yet unknown whether trained PSAs will have opportunities to continue in a similar capacity working with other international NGOs, NGOs in developing countries, or government institutions.

Description of PSA roles in practice

- Community sensitization to the effects of torture and war.
- Identification of clients having difficulty coping.
- Pre-assessment with clients (interview and determination of traumatic events and coping).
- Referrals to other organizations (e.g., food supplies, refugee registration and health care facilities) or to the CVT team for a clinical assessment by professional staff that may also result in referrals to other service organizations.
- Referral and provision of services for intervention strategies: individual, group/family and/or community therapeutic interventions (may also include further education for parents and the client's community). The intervention strategies generally follow a 10- to 12-week cycle of service provision.
- Follow-up with clients; takes place during the treatment process as well as after provision of services (one month, three months, or six months) to measure the level of client improvement (for research and outcome measures) and to improve service provision and treatment interventions.
- Provision of information to the community and assistance in advocacy activities.

Lessons learned & challenges: Taking the tactic to other contexts

Our tactic was first implemented in refugee camps in Guinea, adapted for direct use in communities in Sierra Leone with returning refugees and internally displaced people and later used in refugee camps in Sierra Leone and Guinea set up for Liberians fleeing renewed conflict in their country. In this section of the notebook we discuss considerations for using our tactic in other contexts—both those that involve massive atrocities and community violence and others that may not. Members of other professional fields, particularly the medical and legal fields, have used training models for paraprofessionals to provide services to underserved and remote communities and may be able to learn from and adapt some of the ideas presented here. Our tactic provides an empowering capacity-building process to meet urgent needs of individuals and communities while addressing the responsibility to "do no harm."

Since it is crucial to consider how to reach the individuals and communities in need, we suggest that you consider the following recommendations when exploring this area of work.

OVERCOME FEAR & STIGMA IN COMMUNITIES REGARDING MENTAL HEALTH ISSUES

The issue of stigma must be addressed to open the way for individuals and communities to recognize the impact of massive community violence. CVT's experience working with resettled refugee communities in the United States reinforces the need to provide psychosocial education not only to the newly resettled communities, but also to the professional community and general population as well. Even in countries where mental health professionals are available to provide services, it cannot be assumed that these professionals are experienced in dealing with the trauma of war and torture.

The populations most in need of mental health services often require the assistance of other community members to identify and reduce barriers to accessing help, yet those suffering are most often isolated from their natural support systems. Consider the wide variety of barriers that may hinder people from receiving information or accessing available help.

DEVELOP COMMUNITY INVOLVEMENT & OWNERSHIP OF THE PROGRAM

Great attention and dedication is needed to engage and cultivate community involvement. This is true for gaining moral as well as material support. In CVT's experience, community investment and ownership is heightened when community members are solicited to provide their time, participation and labor to build

meeting places for small-group and individual counseling and the necessary. This participation has resulted in greater openness among the general community toward learning about the effects of war trauma and torture, reducing the barriers of fear and stigma that might have prevented some from seeking help.

PREPARE FOR A LONG-TERM COMMITMENT

The intensive training and supervision model is effective but requires the organization, professional staff and PSA trainees to commit themselves to engaging in a long-term education and skill-building process. The hands-on supervision model has proven to be an effective way to teach and demonstrate skills for providing services and mental health interventions. And the small therapeutic group size is ideal for helping to rebuild connections and social support systems after community devastation. But this capacity-building takes place over the course of many groups and counseling sessions. It takes time for peer counselors to gain confidence and competence in group skills, facilitation and leadership.

It is important to recognize that many PSAs will not have the interest or ability to develop all skills, particularly those needed to facilitate small groups and provide peer counseling without ongoing direct professional supervision. Professional supervisors must therefore plan to manage trainees with different aptitudes and to move some PSAs into other kinds of support roles where they will develop the capacity to work independently and provide support to those PSAs who do move into levels of greater skill development and responsibility.

MAINTAIN PROFESSIONAL EXPERTISE TO PROVIDE MENTAL HEALTH TRAINING & SUPERVISION

In our experience, finding and maintaining the professional staff to carry out the training and supervision has been one of the biggest challenges, and it has taken considerable human and material resources. CVT maintained ongoing advertisements in a wide variety of regional and international networks for professional staff and continued to run these even when positions had been filled in order to ensure a stable and adequate number of professionals in the project at all times.

Whether the professionals come from within or outside the country, skilled expertise is essential to implement this tactic. It is not realistic to expect semi-skilled people to train and supervise unskilled people regarding complicated psychological trauma.

Professional staff have generally remained in the project for about a year, although the project has been fortunate to have some who have stayed for much longer. Because of the need to incorporate the knowledge of professionals from different backgrounds, of the PSAs and of the broader refugee community, it is important to find professionals who are open to exploring and incorporating a wide variety of approaches to mental health and training methodologies.

Experienced administrative staff members are needed for maintaining logistical support systems, including communication and coordination. Attention to building local staff capacity in these skills is highly important for long-term sustainability.

CVT has been fortunate to find professionals from many regions of the world willing to dedicate their skills and expertise in very demanding, unstable and unpredictable situations. Refugee camps and returnee communities are often isolated and difficult to reach, especially during tropical rainy seasons. Not only has this made it challenging to sustain activities and maintain consistency in ongoing training and supervision, but the isolation creates an additional burden on professionals accustomed to having access to other professionals for consultation—in person, by telephone or electronically—and other resources such as librar-

It became very important to train the trainer—to teach the PSAs how to train the community in what to expect from a community mental health program, because at first no one was coming for services. At first it was also necessary for clinicians to devise a method of explaining the effects of war trauma on community functioning. But now, about 85 percent of the PSAs are able to plan and carry out a community sensitization.

Michael Kariuki Kamau, professional staff from Kenya

When I left Liberia, I ran from war. I came into Sierra Leone to seek refuge and lucky for me I came across the CVT. But going through the functions of CVT up to date, really I'm highly impressed, I'm determined to join the field of counseling and I think previously I stated that I'm feeling proud that I'm equipped. Tomorrow, if I go back to Liberia I think I will stay and continue in that direction.

Liberian psychosocial agent

Since CVT came [to Sierra Leone] it is only based in these camp areas. But Sierra Leone has been a post-war country. So there are victims in some areas that CVT is not able to go there or will not be able to open the centers there. I'd like to be trained also as a counselor in order to work for my communities.

Sierra Leonean psychosocial agent

And for my family, let me say, at first, before I started working for CVT, I used to be a hot mother. I used to beat on my children, because immediately if you misbehave I would discipline you. But now I know how to carry on my discipline and I know when and where. I know how to talk to my children more, especially when [the professional staff] taught about the stages of children. Now I developed more skills there.

Sierra Leonean psychosocial agent

ies. The reality of being cut off from these resources adds to the overall stress for the professional and refugee staff. Although professionals have expressed their general satisfaction with having had an opportunity to use their expertise in this manner and to gain valuable experience, conditions do make it difficult for them.

DEVELOP A STANDARD BASE CURRICULUM THAT IS PRACTICALLY ORIENTED & SUSTAINED BY ONGOING SUPERVISION

Due to the diversity and constant changes in professional staff, a variety of curricula for training PSAs emerged from the various professional staff serving in the project. We needed, then, to consolidate these curricula for better consistency of information, skill-building and evaluation. Although flexibility is needed to develop creative ways of responding to community needs, the basic information taught to each batch of PSA trainees requires consistency. This serves to reinforce psychosocial information for old and new PSAs, as well as for the community at large.

> The materials we've been receiving really are, if we can grade them... all college-related materials and most of us have gone to some areas that maybe others working have not really reached. I'm looking at the vision for CVT, and even with my own self, with respect to the future again. Maybe from Sierra Leone CVT will be pulling out, maybe two or three years from now, I don't know the time. But whatever will be the time, sooner or later, our training needs to be validated. Whether we be will used, whether we will be working with CVT in Liberia or we continue working here, I think our training needs to be validated.
>
> *Liberian psychosocial agent*

> Our training has had a great impact on the building up of the community people. You would see that every day there would be lots of fighting maybe between wife and husband or… family to family. But from the training we have been attending here, especially when it comes to problem-solving, when it comes to family counseling, we have been a help to some of these community people. Some of us have overtime work now. We are sleeping at times and trouble happens somewhere. Maybe even if it is not in your community, but people know you are working with CVT. They come to your place and tell you, "If you do not come, our community will not sleep tonight." And we want to be thankful to CVT that, whenever we reach into places like that, the people are going to recognize us. And they are able to pay attention to us and we are able to talk to them and sometimes have them schedule for counseling here. We get them help, so that they can have respect and love for one another in the community. So I will really say that it is because of this training, all of us whose job it is to go back and challenge one another in the community where the police or other authorities in the camps always have to come and arrest people. Now CVT workers can at least go somewhere and try to bring in some peace, have people unite in the community. So that is one great impact I think our training has had on the community.
>
> *Liberian psychosocial agent*

ACKNOWLEDGE THE IMPACT OF STRESS ON STAFF

There is a pressing need to acknowledge the ongoing stress on PSAs and the professional staff, stress caused by the scarcity of basic necessities and of opportunities for refugees to get on with their lives in a productive way. Early in the development of the project CVT made a strategic decision not to provide material support. As a small organization, we realized that we needed to focus our human and material resources on providing the training and supervision for psychosocial capacity-building of refugees. Clients who, after mental health services, became ready to use material resources toward self- and family sufficiency were referred to United Nations agencies and other international NGOs to seek such resources.

The lack of access to psychiatric medications for those who need them is a significant problem that also places tremendous stress upon the professional and refugee staff. In Guinea and Sierra Leone, the only option was to send clients to the main cities—an option generally beyond the resources of refugee and repatriating populations.

The isolation of refugee camps and returnee communities makes it difficult to find recreational outlets to reduce stress for the professional and refugee staff. The refugee staff are in a particularly difficult position, as they find themselves "on duty" 24 hours a day. As the community becomes more accustomed to recognizing the help that the PSAs can offer, the PSAs in turn have less and less time for themselves and their own families for rest and recuperation.

MAINTAIN CONFIDENTIALITY

It is also important to recognize the difficulty of maintaining confidentiality in refugee camps and small community settings. Take time to instill awareness of the need for confidentiality and develop mechanisms to uphold this essential principle for the provision of mental health services.

BUILD ON COMMUNITY STRENGTHS

Wherever possible, engage people working with existing resources in the community and assist them in expanding their own capacity to address the community's needs.

Take time to evaluate community resources and needs. Identify community leaders and determine what resources are available for referrals such as health posts, community health officers, natural and trained helpers (such as traditional birth attendants and religious leaders) and organized groups. Utilize community leaders to help identify venues for the work. In our expe-

rience, particularly positive community investment resulted when the community donated space or labor for a venue. CVT always promises to leave the buildings to the community if the project should end. When seeking a community in which to provide services, besides looking at the trauma prevalence in the community, try as hard as possible to find a secure area with access to a main road.

The use of cultural techniques from the community empowers PSAs and the community to influence, contribute to and participate in the project. It is important to adjust approaches to fit the local context, issues and needs. For example, when UNHCR moved the Sierra Leonean refugees to new camps deeper inside Guinea, it was important to provide support to help refugees settle into their new surroundings and to give the refugees, PSAs and CVT professional staff time to evaluate the conditions.

Be sure to build mechanisms for understanding and overcoming cultural barriers, including barriers of language, religion, ethnicity or tribe. Refugees, the PSAs working with them and the professional staff often find themselves having to communicate with people who do not speak their language or understand their religious beliefs and cultural backgrounds. Serving as an interpreter is one of the first skills that PSAs need to develop and one of the first roles they must perform. This is a difficult, yet essential, skill to have when the professional mental health staff are coming from outside the community in which the PSAs will provide services. Any group seeking to adopt this tactic, in whatever context, should be aware of this issue.

It is essential to develop a system of collaboration, communication and mutual referrals with other organizations, groups, leaders and healers in the community. In the refugee camps, collaboration with United Nations agencies and international NGOs is especially important for connecting refugees to the services that can benefit them most. Traditional healers and natural helpers, both in the refugee camps and in repatriated communities, can often be key to referrals for services.

I didn't know that torture was anything bad. We have been doing it either on the domestic violence side or we have been experiencing torture and never taken it to be anything bad, not until when we joined the CVT family. We were able to come up with some programs and role-play on torture and what is the effect it has on people, teaching us what torture will do to people and the dangerous part about torture. We began to sensitize communities against torture when they came and celebrated the training day with us. We had police and administrators here who were working on a problem, "What if a thief was arrested for maybe stealing... in the camp. What would you do to him?" Some would say the first thing we get him to confess who are the people [who are] stealing.... Some would say we tell him that we take desperate measures against him. Some would say we put him on the pole and torture him until he will say the truth. There were lots of ways of torture that people expressed, that they can punish people to come up with a confession. And from there we came to explaining to them the danger involved in these things. The impact it will have on the people being tortured. They were able to take the messages back and sensitize the community on the effects of torture.

Liberian psychosocial agent

It's hard for [PSAs] to overcome their guilt when clients come with expectations for a solution to their problem that usually involves some material support like a soap-making venture or money for food.

Michael Kariuki Kamau, professional staff from Kenya

Conclusion

The casualties of contemporary war are disproportionately found in civilian populations. In World War I, just 5 percent of the casualties of war were civilians. Today, however, that number is greater than 90 percent.[12] Those who survive have all too often witnessed firsthand the horrors and atrocities of war and yet must face the monumental tasks of rebuilding their lives and communities as they simultaneously cope with loss and devastation.

This tactic was developed by the Center for Victims of Torture to build long-term capacity by training refugees themselves to provide psychosocial support within refugee and war-torn communities. We believe it can be useful to those faced not only with refugee and displaced communities, but with other situations in which communities are trying to recover from trauma with limited resources and tremendous need.

A children's group counseling session.

In the community, if even you are traveling through the community, you know that with all the camps that are here, Jembe has been the only one that CVT has really been working in. So even if you walk in the community you will see that Jembe is a clean community. The people here have been empowered to be able to do something for themselves. They can clean up their own area now, they can wash their things, since most of them have been here and we have been empowering them. And even for our teenagers and our children, if you see them in the community, they will come to you very calm, speaking to you. You can really admire how they can come talk to us because we have been counseling them together, having group sessions with them. And because they are now identifying their values, we teach them things that embody self-esteem, we teach them how to know themselves. And now in the community if you are going around you see that they are actually trying to know themselves. So through the training we are really helping the community to carry on their own personal life. They came with a lot of trauma. They just used to be at home, not even to say hello to somebody. The women they can now visit each other, even the teenagers you see them moving in pairs, living happily and going to school. So I personally, I really learned from CVT that empowerment is really helping the community. *Liberian psychosocial agent*

NOTES

[1] "World Bank approves transitional support strategy and HIV/AIDS project for Sierra Leone." March 27, 2002. World Bank Group. News Release No. 2002/260/AFR, 27.

[2] "Sierra Leonean Refugee Operation." 1999. UNHCR Global Report. http://www.unhcr.ch/cgi-bin/texis/vtx/home?page=search.

[3] "Sierra Leone: Sexual Violence Widespread in War." January 16, 2003. Human Rights Watch. http://www.hrw.org/press/2003/01/sl0116.htm.

[4] "Global Report 2000 - Guinea." June 1 2001. UNHCR. http://www.unhcr.ch/.

[5] Torture is defined by the United Nations 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 another person acting in an official capacity." Note: another person acting in an official capacity pertains to non-state agents acting in a positions of power or when state power is unable or unwilling to function.

6 War trauma is defined as severe, repeated, and/or prolonged exposure to violent events of war.

[7] In 1999, CVT had approximately 40 full-time staff with a budget of U.S. $2.3 million million for its total U.S.-based center services and training programs. (1999 CVT Annual Report)

[8] Hubbard, J., and Pearson, N. "A psychosocial program to address massive community violence experienced by refugees from Sierra Leone." The Mental Health of Refugees: Ecological approaches to healing and adaptation. Eds. K. Miller & L. Rasco. Mahwah, NJ: Lawrence Erlbaum Publishers, Inc.

[9] CVT's "classroom" consists of periodic, three- to four-day trainings, after the introductory training session, that focus on particular skill development or special topic areas. These sessions are provided to all refugee peer counselors for as long as they remain with the CVT project.

[10] The average level of educational attainment is lower for women than men. We have sought to overcome this discrepancy by judging the written responses on content rather than grammatical correctness. In addition, the group interviews allow for observation of the actual interaction between women and men to assess natural skills and relating styles.

[11] For more information regarding the development of a culturally sensitive research tool developed by Jon Hubbard, CVT's research director, please see: Hubbard, J., and Pearson, N. "A psychosocial program to address massive community violence experienced by refugees from Sierra Leone." The Mental Health of Refugees: Ecological approaches to healing and adaptation. Eds. K. Miller & L. Rasco. Mahwah, NJ: Lawrence Erlbaum Publishers, Inc.

[12] Summerfield, Derek. "Addressing human response to war and atrocity: Major challenges in research and practices and the limitations of Western psychiatric models." Eds., Kleber, R.J. et. Al. Beyond Trauma: Cultural and Societal Dynamics. New York, NY: Plenum Press, 1995.

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