From Counselling to Psychosocial Development

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An Anthology
edited by

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and
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Rehabilitation and Research Centre for Torture Victims (RCT)

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Foreword

Since 1998, RCT has worked with partner organisations in the South, which are central actors in their respective country in the field of torture prevention and the rehabilitation of torture survivors. The co-operation has helped the partner organisations and RCT to focus its work thus enhancing their efforts. The co-operation modalities have followed an organisational learning approach emphasising how we can continuously improve our work.

In 2004, RCT adopted its new policy: *RCT Challenges and Targets in a Challenging World*. This policy puts more emphasis on the research and other knowledge-generating activities increasingly linking future interventions with knowledge driven activities. The challenge has been to direct this emphasis to the partnership co-operation, learning from the partner organisations' practices for the benefit of themselves and for other organisations - without diverting the attention from the main objective of these organisations - to improve the rehabilitation practices and coverage for survivors of torture and organised violence, and for the prevention of torture. The knowledge-driven activities will therefore be based on the present practices and the needs for assessing and improving these, to strengthen further interventions in the field.

Counselling is one of the practices that almost all RCT partner organisations undertake. Therefore, it was natural to make it the theme of a professional partnership workshop held in 2004 in the Philippines. Partner organisations from Philippines, Bangladesh, Sri Lanka, Palestine, Kosova, Albania, Honduras, Guatemala, Southern Africa and Denmark presented their counselling practices. The presentations showed that counselling has different meanings for different organisations. Some even questioned the clinical use of counselling in a South context. The workshop also emphasised that a critical perspective is necessary when discussing relevance and impact of a particular intervention *vis-à-vis* other forms of interventions. The practice descriptions are seen as a necessary requisite to be able to assess the possible effects of the counselling treatment/interventions at a later stage. The workshop presentations have been rewritten and edited for this anthology. The whole process from the seminar to write up of the respective articles have had an add-on benefit, because it has led to a sharpening of the respective organisations' understandings of their own counselling practices, because the whole process provided the participants with an opportunity to describe and reflect on their own practices. The fact is that organisations undertaking rehabilitation of survivors from torture and organised violence and the prevention of torture in the South either lack the required funds or human resources, or particular circumstances force them to prioritise other forms of activities.

We hope that this anthology – not claiming to be covering all sorts of counselling practices – can inspire other organisations working with psychosocial interventions particularly in the South. Many people have been involved in making this anthology of counselling practices. In this respect I would like to in particularly thank Aase Young who meticulously have edited almost all the articles, Stina Thurøe for making the anthology a readable entity and Christina Hennings who gave the book the final touch before printing.

Jan Ole Haagensen, Director, International Department, RCT

Introduction

Jone Schanche Olsen and Finn Rasmussen[1]

Challenges continue to exist in the rehabilitation of torture victims. The many years of experience have led to the development of numerous different approaches on how survivors of torture and organized violence can be rehabilitated. Torture survivors around the world have regained their strength and improved their physical and mental well-being, and theoretical understandings and practical methods have been developed. In close collaboration with its international partners the Rehabilitation and Research Centre for Torture Victims (RCT) has contributed to the expansion of rehabilitation of torture survivors. This partnership has progressed and has been taking a more consolidated form during the years. Emphasis has been put on collaboration on methodological development, and sharing and systematization of knowledge and experiences have been important tools. The yearly partnership workshops are key events for such sharing, which typically focus on a specific issue of concern for the rehabilitation centres and programmes.

Partner workshop on counselling

Different counselling approaches and psychosocial interventions have been developed as a response to the various contexts, cultures, political as well as resource situations in which rehabilitation takes place. Reacting to the diversity also among their partner organizations, RCT decided to strengthen the interchange of experiences and discussions on counselling. This resulted in "The RCT Partnership Workshop on Counselling" held in Manila in the Philippines in November 2004 and was organized in cooperation with Balay Rehabilitation Centre. The main purpose of the workshop was sharing practical experiences in the field of psychosocial rehabilitation in order to get a broad overview of the experiences with counselling of traumatized and tortured people in conflict and post-conflict areas as well as in refuge. The idea was that the workshop should function as a familiarisation of the range of initiatives and ideas. Taking into consideration the differences in context, culture, history and working conditions, the goal was not necessarily to pursue a joint understanding and harmonizing of the concept of counselling. The variety of experiences presented during the week-long workshop demonstrated the affluence of existing initiatives and experiences.

The participants in this workshop have all been invited to transform the presentations of their experiences into written contributions. Some of the articles offered in this anthology are factually written versions of the oral workshop presentations, while others have included questions raised, ideas introduced and reflections made during the workshop. In this sense, this anthology of articles seeks to capture the spirit of constructive and engaging interchange of experience and discussion that characterized the seminar. The articles show us that professionalism, creativity, courage and sensitivity to context and culture have been put into action while taking into consideration the political, economical and human resource situations. The descriptions contain a wide variety of approaches, all catering to the perceived needs of defined target groups. The range of target groups are found among people facing problems as a result of tyranny during past-time regimes as

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well as present oppression and human rights abuses. Target groups may contain refugees fleeing from such regimes and includes individuals with the experiences of historic long-time imprisonment and torture as well as survivors of torture newly released and in need of acute assistance. Communities which have been exposed to organised violence to a degree that have destroyed social structures and cultural basis are targets for activities as well, as are groups of victims and survivors' families.

Set in different contexts and situations, different approaches have been developed by dedicated, creative and courageous practitioners. Community programmes have been organised, clinics have been set up, families have been supported and traumatised fellow human beings have been dealt with in ways that are perceived to be considerate, effective and well received by the beneficiaries.

The Manila workshop brought together experienced clinicians from the field of counselling victims of torture and organised violence. Bringing together activists from different organisations with different ideology, different organisational basis and structure, with different levels of human and economic resources and facing different aspects of torture-related problems in different kinds of societies leading to different practices, gave rise to numerous discussions. These discussions did as expected not end with a common definition of target groups or a common programme for intervention. A shared understanding of both what we have in common and what is different was regarded as basis for a joint constructive development. Most of the practitioners contributing to this publication come from organisations in the South and regard torture and organised violence from the perspective of societies where torture and organised violence constitute a real and experienced problem. These conditions have a profound and comprehensive impact on the lives and work of victims and practitioners.

The literature covering the field of psychosocial rehabilitation of victims of torture and organised violence fails to show us which interventions are most beneficial for the victims (Quiroga & Jaranson, 2005). This field of interest is poorly defined, and there is almost no research published on outcome results. There are many reasons for this: the political situation responsible for the violence is contributing to the choice of activities feasible and possible in the actual society, and may oppose conditions for research. The human rights aspects of violations of individuals and communities make it impossible to regard the rehabilitation of torture survivors as a strictly bio-psychosocial problem. Societies in which RCT's partners are working may be oppressive in ways that running a traditional clinic would be illegal and impossible. For obvious reasons it may also be extremely difficult to operate overt community programmes in societies dominated by violence, corruption, human right abuses and torture. The traditional conflict of interest between treatment and prevention of illnesses is also emphasised in this field, since prevention of torture as such includes political activities in societies which may be perpetrators of violence and executors of torture.

The organisations represented in this publication are doing both preventive and rehabilitative work, and reflect the experience of necessary close ties between these activities. The organisations are distinct organisations with different ideologies, approaches and resources – both when it comes to funding as well as human resources. The circumstances in which they work are ranging from at one end RCT in Copenhagen

which is a mainly government funded organisation dealing with rehabilitation of torture survivors in Denmark, an activity which is considered as useful and necessary by all the political parties represented in the the Parliament, Folketinget. On the other end partners are working in violent and dangerous settings, being attacked and receiving death threats. Some of the contributors in this publication are even not acknowledged since their activity is considered that of an enemy of the state and thereby have to be anonymous. Still, it is the idea of the RCT partnership that we do have something in common: A wish to relieve the sufferings of torture survivors and a wish to advocate for a torture-free world.

The publication deals with the issue within four main sections:
I. Concept and overall approach
II. Methodology
III. Cases
IV. Perspectives

Concept and overall approach
Ane-Grethe Madsen from RCT opens the discussion with a review article of the concept of counselling, the main approaches and identification of particular elements in counselling. She dedicates part of the article to the selection of counselling approaches and describes the ways in which the socio-cultural context and other factors come into play. She refuses to formulate a state-of-the-art definition of counselling, which can embrace the use and understanding of this concept across cultures. Instead, she recommends agreeing upon some basic elements in the counselling process. She suggests using the term psychosocial interventions rather than counselling, since it opens up for a broader approach in supporting the individuals and groups in the socio-cultural context.

The subsequent contribution by an *anonymous author* (known to the editors) follows the question put forward in the first article and goes even further by asking: Do survivors of torture need counselling? The main argument of the article is that the traditionally understood concept of counselling as a “talking cure” does not include other aspects of importance for the rehabilitation of the survivors. Two aspects in particular are raised. Counselling has no tradition for dealing explicitly with restoring justice. Nor does it aim to cope with problems within the socio-economical everyday life of the torture victim. The author argues that in order to address the psychosocial situation under which the survivors are living, these two aspects must be incorporated in the understanding as well as in the practical management of counselling.

Methodology
The section dealing with different methodologies and approaches starts with counselling in the family situation. *Melita Kallaba* from the *Kosova Rehabilitation Centre for Torture Victims (KRCT)* gives an introduction to a family approach method developed to attend to trauma and torture survivors in the post-war situation in Kosova. She presents several arguments for choosing this approach, including the increasingly important role the family has gained after the war, where the family has been left with a number of additional responsibilities due to weak state institutions. Further, a family approach complies with the traditional role of familiy ties as well as to the experienced needs in Kosova, since not just individuals but whole families have been affected during the war. Through two cases she demonstrates the approach and its meaningfulness for rehabilitation work in Kosova.

Belinda Labrosse from the RCT describes the intense process a group of Iraqi women experienced together with the psychologist during a one year group analytical treatment. While the group initially was very loose in its objectives, the therapy supported a process where the group activity became more goal-oriented and resulted in the decision to establish a self-help group. The process made the group members more conscious of how both mechanisms in Danish society and aspects of their own cultural background are blocking for their individual development and independence.

In Honduras, the *Centre for Prevention, Treatment and Rehabilitation of Torture Victims and their Families (CPTRT)* has developed a highly integrated mental health approach. *Eliomara Lavaire* explains how and why violence within the family is perceived as a product of organized violence in the Honduran society. As a consequence, she states, prevention of violence needs to be approached through an integrated manner working with individuals, families and communities at the same time. On this basis a methodological approach, which focuses on mental health building upon involvement of community leaders and support from popular organizations, has been developed.

Local cultural understanding plays an important role in counselling work in many of the experiences presented. *Maria Rohr* from the *Human Rights Office of the Arch-Bishops of Guatemala (ODHAG)*, describes how the local culture and what is labelled historical resources are used actively in the rehabilitation. Her point of departure is the rich Mayan culture and exposes its historical resources for improving the mental health of the populations affected by the civil war. The military based dictatorship targeted the destruction of these resources, knowing their importance for identity and meaning of life for the Mayan population. The article describes how these resources are now revived and brought into action in a national programme supporting the mental health of the communities affected by the organized violence.

In the Guatemalan programme working with historical resources, the counsellors use massage and other physical treatment as a natural part of the counselling. This aspect of counselling is the focus of the article by *Lone Tived* from RCT. She argues for the relevance of a body-oriented approach in counselling for survivors of torture and organized violence. Understanding the body and mind as integrated parts, she describes how experiences with this approach have demonstrated potentials to empower traumatized persons. Still, the article concludes, since the relation between body and mind is perceived differently in different contexts, caution must be taken when transferring a body-oriented approach from one culture to another.

The final article in this section deals with counselling as an integrated part of an empowerment programme based on survivors of torture organized into “Victims Associations”. Emphasising mutual support as a powerful tool in areas of social, legal, economical as well as psychological challenges, *Akram H. Chowdhury, Zahid ul Arefin Choudhury* and *Saifun Nesa Zaman* from the *Bangladesh Rehabilitation Centre for Trauma Victims (BRCT)* describe the establishment of such associations. As innovative tools to combat torture and rehabilitate torture victims, these associations linked with self-help related counselling activities strengthen the outreach facilities towards torture victims. The authors express the long-term perspective as the creation of a society where

communities in addition to documentation and prevention of torture, proactively integrate and rehabilitate torture victims. Through the victims' associations, torture, survivors may be powerful agents in the fight for making the state respect democracy and human rights.

Cases

The cases presented in the following section contain snap-shots of the day-to-day work with counselling and additionally the reflections of dilemmas and experiences gained from this effort. Starting in the *Philippines*, *Ernesto A. Anasarias* and *Brenda Escalante* from *Balay Rehabilitation Centre* describe how they work with counselling in multi-ethnic communities devastated by armed conflict. Combining therapeutic techniques with local social practices and indigenous rituals, they seek to establish interaction in a mutual helping process at the individual, family, group and community level. The authors argue that psychological and social responses need to consider the socio-cultural dynamics. Following this line of thought it is necessary that concepts, values and practices derived from other countries are adapted to the local context.

The following contribution from *Anwar Wadi* of the *Gaza Community Mental Health Programme* also stresses the importance of a profound understanding of the local context in order to succeed with rehabilitation of victims of torture and organized violence. While the cases from the Philippines above focus on the cultural context, the example from Gaza attends to the political context including the motivations that inspire political activities. The programme deals with the traumas and damages in humans and social relations mainly caused by the Israeli oppression and abuse of the Palestinian people. This is done through a community health approach focusing on family, networks and society, seeking to rehabilitate individuals and restore social capital. Emphasizing the fact that this work is carried out under great risk, the author underlines the importance of continued external support to these efforts.

The final cases written by an *anonymous author* (known to the editors), focus on rape in Zimbabwe. The author explains how the conditions for rape are actively brought about or condoned by the Government. This may include circumstances that make it possible for the rapist to frame the common crime as a political act, thereby avoiding legal prosecution. Other government related conditions mentioned in the article are the undermined judicial system, which leaves only meagre chances for victim to find justice, and the lack of support from the health system. Therefore, the author argues, the treatment of rape victims needs to combine therapy with human rights activism.

Perspectives

In the final section perspectives are laid out for future areas of counselling that are important to attend to. One major challenge for counselling is how to establish a monitoring system, which can be used to adjust, and follow-up developments of a treatment programme and also serve to identify the results. From *Balay Rehabilitation Centre* in the Philippines *Ernesto A. Anasarias* and *Brenda Escalante* explain how they have set-up a system that not only monitors but also seeks to enhance the capacities of the community partners. Through a case, the authors present how this works in practice, concluding that a participatory approach to monitoring is highly relevant. Nevertheless, the article concludes, it will require a great effort to develop and establish a monitoring system, which functions in a simple and manageable way.

Enhancing monitoring and evaluation

This final article puts pressure on one of the soft spots in current work on counselling and on rehabilitation of survivors of torture and organized violence as such: how to monitor and how to measure effects.

In all developmental and humanitarian activities, we are in need of knowledge about how to most effectively and efficiently use the available resources – in our case to alleviate the suffering of those exposed to torture and organised violence. It is an ethical imperative to provide the most efficient and effective rehabilitation.

In a study published by Quiroga and Jaranson (2005) updated and complemented previous desk study reviews of the torture rehabilitation literature. Stating in their review that it has been universally accepted that *"a multidisciplinary approach is the best treatment for torture survivors"*, they point out that although *"the approaches are many, little consensus exists and treatment effectiveness has not been scientifically validated by treatment outcome studies."*

Taking up this challenge, we have to improve and intensify the monitoring and evaluation of our activities. The article of *Ernesto A. Anasarias* and *Brenda Escalante* in this publication demonstrates one way this challenge can be met.

Still, more efforts need to be launched in this area. Quiroga and Jaranson (2005) are arguing for scientific validation of treatment effectiveness. In other words, they call for evidence-based rehabilitation of survivors of torture and organised violence. The lack of validation reflects the complexity of factors influencing the lives of survivors of torture and organised violence. Eventual evidence-based research is in need of identifiable indicators closely related to the rehabilitative activity. There is also certain call for satisfaction of requirements to the conditions under which such research can be carried out.

When it comes to "soft" areas like mental well-being, the possibilities to isolate factors (or *the* factor) influencing the conditions are limited, as are seen in all research on psychotherapy. Quantitative research methods in this field has proven useful in evaluating highly schematic interventions like cognitive therapy, but failed to give evidence for other therapy forms building on relationship and mutual understanding. Qualitative research may give different kinds of knowledge than "hard core" evidence. Participatory action research may well give us different kinds of perspectives and research results.

Monitoring and evaluation continues to be a challenge, and no clear road map to meet these exists. Some suggest WHO's "International Classification of Functioning, Disability and Health" (ICF) as a possible framework to provide answers to some of the questions of what kind of interventions are effective under which circumstances. Others point to the limitations and restrictions of this framework. Nevertheless, only the discussion of concrete options for monitoring and evaluation can lead us ahead and eventually define ways to effectively measure whether our interventions alleviate the suffering and empower the survivors.

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I. Concept and Overall Approach

Framing the concept of counselling

Ane-Grethe Madsen[1]

Although numerous approaches to counselling exist, some basic elements of the concept can be defined. The counsellor's ability to establish trust, convey empathy and facilitate the process in a structured way are key elements. No universal approach can be defined since counselling has to be understood according to the socio-cultural context where it is practised. This is why counselling can be broadened to include psychosocial interventions, thereby giving room for the selection of the most appropriate approach that is available in the local context.

Introduction

It is no easy task to approach the concept of counselling, since no authorised definition exists. Neither does this article pretend to come up with a final definition of the concept. Instead the aim is to get a better understanding through discussion of existing definitions and ways in which counselling is understood as well as through the identification of basic elements. The discussion will focus on psychosocial counselling in relation to trauma and torture victims, and will be illustrated through examples on counselling and treatment of trauma and torture victims.

A variety of approaches can be used in counselling and therefore counselling is utilised in different ways in different contexts. Often the concept of counselling is used to describe psychosocial interventions, a term which covers a wide spectrum of understandings, approaches and methodologies. The approaches used cover a wide field. At one end of the spectrum, counselling is situated in a psychodynamic conceptual frame mainly performed by counsellors with a longer academic educational background, often psychologists or psychiatrists trained in psychotherapy. At the other end of the spectrum, counselling is the practice-oriented intervention undertaken by lay persons with basic training or by nurses, community workers or a religious leader.

Although used within a broad spectrum, counselling is generally speaking understood as a “talking cure” in which the counsellor uses the ability to listen and convey empathy and understanding as well as to establish trust and a supporting relationship. This is a process which resembles what the Danish philosopher Søren Kierkegaard qualifies as the change-seeking relation to a person: “if one should truly succeed in leading a person to a certain place, one should first of all find him where he is and start from there” (Kierkegaard, 1963: 23 in Elsass, 2003: 394).

One well-known definition of counselling, when dealing with the individual, is the following based upon counselling people with mental health problems.

"*Counselling is a systematic process which gives the individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well being. Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crisis, working through conflict, or improving relationships with*

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others. Counsellors therefore focus on client choices in their life circumstances, as a basis for their work." (*Bateman et al., 1999).*

The key aspects of this definition are the provision to the individual of a process with guidance and support to explore, clarify and take decision on of ways of living. In this process a space is created for talking about the problems that the person is most in need to talk about. This means talking about daily difficulties as well as talking about more painful experiences of the past.

Four levels of intervention

Many definitions and approaches, including the above-mentioned, can be and often are criticised for putting focus on counselling at the individual level, thereby reflecting their basis on Western ideology and approaches. While the individual level is probably the level where most counselling takes place, it is important also to include counselling as practised at three other levels, namely the in-group, family and community levels.

Counselling at the *individual level* typically supports the client's own resources and ability to process and cope with past trauma and present demands. The counsellor is intended to be a catalyst while the clients are considered to be the experts in their lives and their problems.

The aim of *in-group counselling* is for the individual to benefit from being part of a group of people who have had similar traumatic experiences. The support from the other group members may minimise the feeling of being isolated, the feeling of facing problems alone as well as the feeling of mistrust towards others. Group members may often benefit from learning from other members' experiences and the group dynamic process can thereby increase learning from being part of a group. These experiences can be transformed to group relations outside the counselling group. The methods and approaches used in in-group counselling are often based on empowerment strategies and participation. Techniques and theories from social psychology and pedagogy are frequently used, including psychoeducation and group dynamic theories. The group-oriented approaches may be particularly useful and appropriate in the contexts in the non-western cultural contexts.

Family counselling attempts to restore the basic social unit. The family structure is often the most appropriate place to find the support and care to improve healthy dynamics. When relationships between family members, mutual understanding and dynamics are disturbed, assisting the family can be very beneficial. Family discussions, deliberations, sharing of problems, expression of emotions, unified functioning of family, co-operative efforts and joint participation in social functions and religious ceremonies/festivals can nurture family unity and positive health dynamics. Psychoeducation can also be used in family interventions supporting the process of integration, re-integration and empowerment of coping strategies related to reactions to painful experiences. Studies demonstrate that family counselling and the creation of a space for talking about daily difficulties and more painful experiences of the past can help preventing re-traumatisation (Montgomery, 2004).

Given that people are not just individuals with individual needs but are also part of a family that belongs to a local community, counselling may be one of the approaches used at the

community level as an important psychosocial intervention. Counselling at the community level typically seeks to foster psychosocial health through personal, group and environmental change for the individuals and to restore a sense of security, create a sense of belonging, and of a self-generating community (community healing and empowerment). Rebuilding community networks and institutions are frequent focus areas. Increased employment and economic activity to improve standard of living may also be an integrated part of this work, as demonstrated by Quiroga & Jaranson (2005). Further, prevention of torture and organised violence may be part of the perspective for this work, working on the assumption that if people talk about the problems they have, many future and problems that are more serious may be prevented.

Community based counselling is often combined with individual and family counselling. In particular, this is done to assure that those who are in need of more assistance than others will be identified and referred to additional supportive measures.

The local traditions and values determine the appropriateness and applicability of counselling in the community. The local community, for example, can either support or prevent the emotional healing after an assault. After a rape, the victim's membership in the local community can be affirmed and attention and support can facilitate her healing. But this may be totally different in another community. Here the rape can stigmatise and cause exclusion from the local community, which will eventually worsen her trauma (Harvey, 1991).

Approaches to counselling

Some may differentiate between psychotherapy and counselling, by underlining that counselling includes more directive techniques than psychotherapy. Others, working from a client-centred perspective, do not differentiate between the two forms e.g. Rogers (1961) and Elsass (2003). Many counsellors work in an eclectic manner, choosing among different approaches depending on the needs of the client, their professional background and the actual context. Therefore a few selected approaches have been identified to illustrate their usefulness in the counselling of victims of trauma and torture in certain contexts. These presented approaches do not cover the whole area of psychological approaches.

The cognitive-behavioural psychology approach

The cognitive-behavioural psychology approach came into existence in USA in the 1950s and the 1960s. Central figures in the development were Arnold Lazarus and Donald Meichenbaum. The cognitive theory looks at the relations between thoughts, emotions and behaviour. The central cognitive method includes a cognitive re-structuring where the client is helped in the process of recognising and acknowledging inexpedient negative patterns of thinking, understanding the unfortunate influence of the negative thinking and to changing or replacing the problems with more expedient and reality related thinking patterns.

Following this theoretical framework, cognitive counselling is about examining how we can think and reprogramming the brain by affirming new ways forward. Counselling therefore focuses on becoming aware of and changing negative ways of thinking.

For victims of trauma and torture the person may find him/herself in a state of confusion after the trauma. This confusion can become chronic and the individual continues to think that the world is unpredictable and a dangerous place, and consequently feels vulnerable. Furthermore, a traumatised person often tends to avoid stimuli which are associated with the trauma. This can be seen as a natural reaction but avoidance behaviour may become routine through new conditioning. The avoidance then works as a reinforcing factor and avoidance behaviour becomes a problem in itself.

The maladaptive effects of these conditioning processes can be diminished by exposing the traumatised person, in a non-traumatic situation, to the stimuli that have become associated with the traumatic experience. This exposure can be accomplished by various behaviour therapeutic techniques, such as flooding in imagination or other kinds of therapeutically controlled visual imagery (Basoglo, 1992).

Client-centred, non-directive counselling
Empathy is fundamental in all forms of treatment, and victims of trauma and torture are especially sensitive to the attitudes of the counsellor and the ability of the counsellor to create a trustful relationship and to convey empathy. These elements are valuable factors in the client-centred counselling approach developed by the psychologist Carl Rogers, by many considered to be the most influential psychologist in American history. Rogers discovered, in a scientifically verifiable way, that if you provided empathy, unconditional acceptance and congruence to people who could connect with you, they felt a great deal better about themselves in a consistent way. Based on this finding a client-centred and non-directive counselling approach was developed.

Congruence and empathy are closely related factors in person-centred psychotherapy. Rogers (1978) believes that the counsellor needs to accurately perceive and feel the client's feelings and personal meanings, then convey this empathy to assist the client in achieving greater comprehension and control over his/her behaviour and circumstances.

Counsellor attitudes are considered to be of paramount importance in facilitating the relationship. Rogers maintained that there are three counsellor attributes which release a growth - promoting a climate in which individuals could move forward. These are congruence, empathy and unconditional positive regard. The attitudes of the counsellor is considered to be essential in facilitating the relationship and he or she must be genuine, real, open, authentic and transparent for this to succeed (Breeda, 2004).

Counselling of victims of trauma and torture also demands the ability of the counsellor to convey empathy. This can be understood as awareness of the thoughts, feelings or state of mind of others, perhaps by means of some degree of vicarious experience of others' feelings or mental states. One must be careful not to confuse empathy with sympathy. Confusion may make the counsellor either too distant or too emotionally involved. In this sense, being empathic is to be outreaching while at the same time keeping a professional distance.

Psychoeducation
Psychoeducation is a very important approach in the counselling of victims of trauma and torture and is often an integrated element in all approaches (individual, group, family and

community). The aim is to help the person understand the reaction that he or she is experiencing, as this understanding offers relief and helps the person to feel normal (Hermann, 1992).

In psychoeducation the counsellor will convey the message to the client that these problems are in some way familiar and that treatment is possible. Explaining the cause of symptoms and placing the clients' experiences within a conceptual framework is often called psychoeducation. The purpose is to demystify and de-stigmatise the symptoms and to improve readiness of coping under stress. The aim is also to improve the knowledge on health and legal rights. A careful explanation of how severe psychic trauma is connected with current symptoms can help the client in developing insight into his/her problems. Many clients are preoccupied with their emotional reactions, sometimes to the extent that they are afraid of going mad. This fear may be related to the fact that the client does not understand his/her own emotional reactions and personality changes (Eitinger, 1960). For this reason, Genefke (1984) considers it of vital importance to explain to clients who are torture victims that torture is aimed at breaking the victims' personality.

Psychoeducation is a clinical pedagogic method often supplemented with small activities and exercises, carried out in small groups or individually. Psychoeducation is not therapy but the facilitator can act therapeutically when dealing with clients' experiences and when summing up in a generalised form.

Empowerment and help to self-help are important elements in psychoeducation where the idea is to increase learning through participation and action. This is based on the theory of Freire (1970, 1982). The central core is the empowering process, where knowledge is considered as power and the sharing of knowledge as empowerment. The purpose is to enable the person and the family to take action and to make decisions and choices. In a group, this is done through dialogue with the participants.

Trauma Counselling

While there are many ways of assisting trauma survivors, trauma counselling is a method developed with trauma as its specific focus. Unlike other forms of counselling, trauma counselling tends to be structured and directive. The aim is to allow expression of the traumatic experience and related feelings and to do this in a manageable way, within a safe relationship with someone who is in control of the process. The approach integrates psychodynamic[2] and cognitive-behavioural approaches for the treatment of psychological trauma. That is an explicit recognition that trauma impacts on both internal and psychological functioning and thus requires a treatment approach which addresses internal psychodynamic processes and uses structured and problem-oriented interventions.

[2] Psychodynamic counselling is derived from psychoanalysis and the work of Freud and subsequent psychoanalytic theorists. It is a model that uses psychoanalytic concepts to explain human growth and development, and the nature of psychological problems. Psychodynamic counselling uses the therapeutic relationship to gain insight into unconscious relationship patterns that evolved since childhood. Memories and other evidence of early relationships are used to make sense of current concerns. The process of change occurs as clients become more aware of the power of the unconscious, including defence mechanisms, instincts and rules for life, to influence behavior, and hence more able to control their actions and responses (The University of Leicester).

The model consists of five components, which can be introduced interchangeably depending on the needs of the client[3]:

1) Telling/retelling the story. This allows the client to give expression to the often unexpressed feelings and fantasies, an act which may prevent repression and displacement into other symptoms. The detailed telling of the story encourages confronting rather than avoiding stimuli and this serves to reduce anticipated anxiety associated with the stimulus.
2) Normalising the symptoms. The client's symptoms are discussed and empathised with, while at the same time providing education about PTS symptoms. Reassuring the client that his/her responses are normal reactions to an abnormal event.
3) Addressing survivor guilt or self-blame. This serves various functions, e.g. facilitating the restoration of self-esteem.
4) Encouraging mastery. In this phase the counsellor assists the client to carry on with the tasks of daily living and to restore the client to previous levels of coping.
5) Facilitating creation of meaning out of a particular event that requires the counsellor to engage with the client's belief system. The model is short-term in nature, ranging from two to fifteen sessions. According to the Counsellors' Appraisals of the Wits Trauma Counselling Model, the model has been found applicable across cultures and could ideally be offered in conjunction with family counselling and not be limited to a focus on the individual (Herman, 1992 in Hajiyiannis & Robertson, 1999).

Common elements in basic counselling
Despite the different theoretical frameworks used and the variety of approaches and methodologies that there exist, it can be argued that there are certain elements which must be present in counselling work in order for it to be successful.

Importance of counsellors' self-reflection
To be able to help others it is important for the counsellor to work through own traumatic experiences and to develop an awareness of own feelings, strengths and limitations. The counsellor often has to deal with moral, philosophical and political issues that emerge during counselling. This is potentially problematic, especially when a client's view on these issues differs from those of the counsellor. Some counsellors have adapted a "humanitarian" approach, which allows for differences in views while others stress the importance of "solidarity" with their clients. Basoglo (1992) argues that if there are major differences in the thinking of counsellor and client it is likely to undermine the therapeutic alliance, and that this might be one of the reasons for dropouts in therapy in general.

Establishing trust and rapport
Studies on what clients find most important and helpful when receiving therapy show that most importance is given to the need for the counsellor to be a caring person able to establish trust, including the ability to convey empathy. These characteristics ensure that

[3] The Wits Trauma Counselling Model was developed by staff at the Psychology department at the University of Witwatersrand. The model was formulated using case material from hundreds of clients presenting various forms of Post Traumatic Stress. The model is applied in cases of acute stress and Post Traumatic Stress Disorder (PTSD), but is not considered appropriate in cases of complex PTSD, nor in cases of continuous traumatic stress where long-term psychotherapeutic intervention is required (Herman, 1992 in Hajiyiannis & Robertson, 1999).

the client feels respected and understood. This indicates that establishing trust and rapport is probably the most important part of any intervention in relation to victims of trauma and torture. Without trust, the counsellor, even with the best techniques or methods, will not be able to help the person. Survivors respond when counsellors offer caring eye contact, a calm presence and are able to listen with their heart. Rapport refers to the feelings of interest and understanding that develop when genuine concern is shown. Conveying respect and a non-judgemental attitude are necessary ingredients for building rapport. The counsellor may build trust if he/she is consistent, reliable, organised, confident and able to convey empathy (Herman, 1998). Important in this respect is also that client and counsellor can identify a safe place for counselling where confidentiality can be obtained. According to Rosenbaum (1996), the qualifications of the counsellor are very important considering the outcome of treatment regardless of the methods or techniques, or "schools" the counsellor is referring to.

Assessment and motivation
The motivation of the client is crucial for counselling to succeed. Therefore, assessment of motivation for psychosocial treatment is needed before entering into a counselling process. The importance of the counsellor to meet the needs of the client and the precise identification of the problems the client is facing are part of this assessment. According to Basoglo (1992), experience shows that those survivors who are aware of the connection between their symptoms and their past traumatic experiences appear to be more motivated for psychological treatment. It is important to take the socio-cultural background of the survivors into consideration in the assessment process. Some survivors may be from certain cultures from certain parts of a particular country where ideas of counselling/psychotherapy are not recognised. In such cases an offer of counselling may be rejected by the client.

An assessment of the client must be made by professionals as part of a treatment. The assessment should include a bio-mental-social health status. Not only the symptoms but also the levels of functioning before and after the trauma experience are important factors in the assessment (Quiroga & Jaranson, 2005). Especially when counsellors have rather poor training, the assessment by experienced health professionals is needed. The assessment should clarify whether there is a need for specialised treatment, including medical or psychiatric treatment, and whether or not counselling is the right choice.

Choice of approach
The choice of approach when counselling victims of trauma and torture is based upon 3 overall aspects: the socio-cultural context, the needs of the client and the resources available in the actual context, including human, educational and economical resources.

The signification of the socio-cultural context
Much of the work with victims of trauma and torture is carried out with clients from non-western cultures in various contexts such as the home environment, neighbouring countries and Western societal contexts. The emphasis on research and practice has been limited to the Western world's view. Allodi (1991 in Pelzer, 1996) defines two categories of treatment settings geographically: "The North", which mostly comprises countries of final resettlement, such as industrialised nations in the continents of Europe, North America and Australia; and "The South", which mostly comprises totalitarian "Third

World" countries where torture most often is practised. In "The North", torture is viewed as having medical and psychological consequences in the shape of traumatic stress and treatment follows this approach. In "The South", torture has been viewed as a component of the socio-political process, requiring preventive action and social change.

Conflict communities may suffer from massive socio-economic, political problems and problems related to broken networks, as well as stigmatising attitudes, which further the isolation of certain groups. People need support and counselling regarding their traumatic experiences as well as for the everyday problems of the family and the local community. Therefore, it is best that the local counsellors carry out counselling or psychosocial interventions because they have knowledge about the local community's resources, institutions, culture, history and traditions. Also, the local counsellors are known to and accepted by the community. Traditionally health is seen as a means to increase the health conditions of community members and linked to political transformations.

According to Clark (2002), the concept of trauma has dominated the discourse regarding psychosocial healing after war experiences and violence. Many of the international experts/donors have focused on trauma and the Post-Traumatic Stress Disorder (PTSD) diagnosis. This approach has given rise to reflections regarding the various risks connected with focusing on trauma. The Western assumption is that it helps the client to bring up feelings and verbalise the pain, while ignoring the local traditional ways of helping. Working from this assumption entails a risk of individualising rather than seeing the problems in the collective social context. Furthermore, the medical term *trauma* inhibits the responsibility and empowerment of the survivor. The diagnosis PTSD emphasises the anxious and emotional state as well as other symptoms that people experience after a chock. The trauma approach may even worsen the problems of social stigmatisation, isolation and lack of integration into the community as this approach may lack tools for assessing the socio-cultural and human right needs as well as the relevant development strategies. The socio-cultural context may be crucial in determining the level of intervention and may either increase or decrease the motivation of the client and determine whether or not the intervention is appropriate and beneficial.

In most cultures it is tradition to help people with problems, often through talking. But in some situations it might not be healthy for the person to talk about the trauma experiences. However, using health as the entry point for interventions holds certain advantages; as health is not perceived as a politically dangerous discipline it can effectively be used as a first step towards addressing social and political issues in the community.

The needs of the torture survivor

Torture survivors living as displaced individuals in the country of origin or as migrants in a host country have multiple medical, psychological and social needs. The combination and degree of these needs are different in each individual or each family.

According to the desk study on politically-motivated torture and its survivors by Quiroga & Jaranson (2005), the most urgent needs of torture survivors and refugees are: housing (shelter), food support, income support, employment, medical care for the individual and/or family, mental health care for the individual and/or family, advice on legal or migration

matters, child care, schooling for children, local language classes and social support. Wherever survivors of torture live – in the country of torture, a neighbouring country or in a remote context – these matters are always important.

The choice of a given approach depends on the specific needs and the degree in which the family and community is affected. Willigen (1996) argues that culturally sensitive mental health assessment must be developed and used to identify the mental health needs of refugees and other displaced people.

Counselling may not be an option if the person is in an insecure situation with lack of shelter and food without an income to support the family. Here the effort focuses on how to create a safe environment and to provide shelter and food. To meet the mental health needs, psychoeducation may be the best approach, as it increases awareness. Hereby the person is helped to better understand the reaction that he or she is experiencing and to see the connection between his/her symptoms and the past traumatic experiences. Psychoeducation may be the first step in the process of introducing counselling to victims of trauma and torture. In other cases medical care has first priority, as pain or other physical problems are most dominating and must be solved before discussing psychological problems.

If rehabilitation centres for torture victims are available in the local context they will generally have programmes to fulfil some of these needs, such as medical care, or they may refer the clients to migrant resource centres, community health clinics, hospitals or other facilities that can provide these services.

The resources available in the local context

Veer (1998) argues that in developed, Western countries many varieties of counselling are practised. In most countries, counselling is seen as the job of professionals. These professionals have taken part in extensive training over several years. In some countries, they must have an academic degree before they can take part in a course to become counsellors. These highly educated academics are in some countries called psychotherapists. The education these Western counsellors have undergone often includes a lot of psychological theory as well as knowledge of psychiatric disorders. Among Western counsellors, various approaches to counselling can be distinguished.

In many Western countries, refugees either live alone or in ghettos, isolated from the native population. Asylum seekers have to acquire refugee status through a lengthy and often traumatising asylum procedure. In many countries, they are allowed neither to work nor to study during this period. After being granted asylum they are often unable to find employment or forced to work in jobs for which they are far too highly qualified. Moreover, refugees are confronted with living in exile, which means a continuation of their traumatic stress. The stress of seeking asylum has implications for the treatment of tortured refugees in countries of final resettlement. In addition, the poor social position of refugees and asylum seekers becomes a major source of the psychosocial problems in counselling (Veer, 1998).

According to Willigen (in Peltzer, 1996), the rehabilitation approach used for torture victims is generally multidisciplinary and comprises physical, counselling/psychotherapeutic, legal,

educational and social help etc. Some centres have a clear political and/or religious position and are not restricted solely to care. Torture is considered a form of political repression and the rehabilitation organisations consider it part of their responsibility to charge publicly the repressive regimes with their violations of human rights. The rehabilitation of torture survivors requires specialised training of professionals. The primary objective is to rehabilitate and reintegrate torture survivors into society so that they can control and take responsibility of their own lives. In such settings the approach is universalistic.

In countries where torture is still practised, treatment resources are usually limited. Psychologists and psychiatrists may be a rarity and concepts such as mental health may be poorly understood or simply not be accepted. Therapy for individuals is rarely available to residents of poor countries, where most conflicts now take place. Community-oriented programmes are therefore the most realistic option in many settings and probably the most beneficial.

The ideology in relation to the psychosocial approach includes an ecological system, the experiential approach, anthropology and the public health approach, which focuses on prevention. The approach is relativistic. The public mental health programmes use a decentralised and self-sustaining approach aimed at adults, adolescents and children. Treatment in countries in "The South" includes preventive measures and explicit goals of re-integrating the individual into society, increasing a feeling of solidarity and safety.

Conclusion

In counselling there is not only one approach and the concept of counselling includes different approaches depending on the socio-cultural context. Counselling has to be seen and understood in the context where it is practised. Therefore, it is problematic uncritically to transfer the counselling concept from one context to another. Counsellors must therefore use locally adapted approaches, which address the problems that clients or communities face. In some areas, the victims of trauma live in very unsafe environments and their main needs are survival and basic necessities. If these needs have been met, other needs may surface, including social welfare and mental health needs.

Although a common definition is not formulated, some basic common elements exist in counselling. These elements include, as a minimum, the counsellors' ability to establish trust and rapport and to facilitate the process in a structured way.

The concept of counselling has a wide range of meanings and interpretations. Some define counselling very strictly according to a given theoretically framework (often in the "North" countries), while others have a more broad understanding of the concept (often in the "South" countries), where psychotherapy for individuals is rarely available and the needs of the clients are determined by the significant socio-cultural context and the resources available in the actual context.

Psychosocial interventions might be a better term than counselling because it opens up for the increased use of different interventions according to needs of the individual in the specific socio-cultural context. Psychosocial interventions may include all the interventions available and appropriate and ideologically the interventions include the psychosocial

approach, the ecological system, the experiential approach, anthropology and the public health approach. Finally, psychosocial interventions are problem-oriented and focus mainly on resources and coping and less on illness and diagnosis.

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Do survivors of torture need 'counselling'?

Anonymous author[1]

Traditionally, the concept of counselling does neither encompass getting justice done after "having been wronged" nor how to cope with problems within the socio-economical everyday life of the torture victim. These aspects must be incorporated in the understanding of counselling, which should be seen as human rights activism working to "set things right again".

Introduction

"*The hook gripped into the shackle that held my hands together behind my back. Then I was raised with the chain until I hung about a meter over the floor. … [W]hen hanging this way, … for a short time you can hold at a half-oblique through muscular force. During these few minutes, when you are already expending your utmost strength, when sweat has already appeared on your forehead and lips, and you are breathing in gasps, you will not answer any questions. … All your life is gathered in a single, limited area of your body, the shoulder joints, and it does not react; for it exhausts itself completely in the expenditure of energy. But this cannot last long … And now there was a crackling and splintering in my shoulders that my body has not forgotten until this hour. The balls sprang from their sockets. … I fell into a void and now hung by my dislocated arms, which had been torn high from behind and were now twisted over my head.*" Torture, from Latin torquere, to twist. (Améry, 1999, p. 32)

Given this case example, the question that I chose for my headline may seem superfluous: who, after such an experience, would not need help? Wait a minute, however: if we agreed that indeed this victim needed counselling, would we actually be clear in our minds about what kind of help we were talking about? It should be sobering to listen to somebody without 'counselling' qualifications, but who has been active within human rights and against torture for many years; well toward the end of the workshop where the contributors to this volume met she remarked: "We are talking all week long about counselling, but nobody seems to know what it is!"

What would be a qualified 'counsellor's' reply? I think it is fair to assume that s/he would refer to help and support, given to one person alone or several together, with one or more problems, by way of listening and talking (employing certain communicative techniques), all the while being non-judgemental and empathic. Although psychotherapy and 'counselling' are both considered talk therapies, s/he would probably mention, as distinctions between the two, that the latter needed (much) less training and was (much) shorter in its application, thus low-cost in comparison. These characteristics – easy to learn, quick to apply, cheap – would be particularly prominent in a version called 'basic counselling'. This notwithstanding, 'counselling' would have a beneficial effect. At the mentioned workshop, it may have been this too-good-to-be-true combination of features which tempted another non-counsellor to ironically define 'counselling' as "a cost-effective 'magic bullet' in contrast to psychotherapy". And he had a point: if such a thing indeed existed – easily taught, quickly done, cheap and beneficial – to call it a 'magic bullet' would not be an exaggeration. Rather it should come as a surprise, then, that it took until the final

[1] The author to this article has wished to be anonymous. The person is known to the editors.

quarter of the last century for the magic bullet to be eventually detected. Or does it perhaps not exist? And if it doesn't, what kind of help should survivors of torture like Améry then be offered?

Case story

On her way back from school in rural Zimbabwe, 18-year-old L. was apprehended by eight uniformed men armed with sticks and guns, and was taken with two other school girls to a makeshift camp in the bush. There they were kept in a tent for three days without food. The men took turns raping them. All three were raped at the same time, or one would be raped as the other two watched helplessly, wondering who would be next. Besides being raped, the girls were beaten and threatened with death. They escaped on the fourth day when the men went on patrol and left them unattended. L. does not draw any explicit links between her ordeal and Zimbabwean politics; she does not imply that she was targeted for political reasons. It seems that in her understanding, the perpetrators were a law unto themselves who, whilst campaigning for the ruling party, could do whatever they wanted.

Not long after her escape, L. crossed the border illegally and went to Johannesburg. One of her reasons to leave home was the way her family handled her plight. When the question was raised of what should be done, an uncle of hers, a ruling party activist, said that raising the issue in public would discredit his party and the "land question"[2]. The message to the entire family (or rather the implicit threat) was very clear; as L.'s granny remembers: they were supposed not to take any action at all!

In Johannesburg, L. found a group of people who listened to her and helped: they organised accommodation, found a psychiatrist who put her on antidepressant medication, mediated between her and a locally resident aunt with whom she felt less than welcome, got her into a catering training scheme, contacted her relatives back home and provided food for the grandmother and younger siblings whom L. had left behind and imagined, with good reason, to be starving. Presently, she has successfully finished her catering course and has applied for political asylum. With the group's support she has overcome the formidable obstacles erected by the South African immigration authorities, so that she can now be legally employed.

I saw L. in the company of her friend, another girl from Zimbabwe, who when needed doubled as translator. My first impression was that of a young woman in reasonable control of the situation and seemingly happy to meet somebody from home. I introduced myself as a doctor with some basic knowledge of her case, and asked if she was prepared to talk to me, to which she replied "yes". Knowing about her reluctance to talk to men, I assured her that she did not have to speak about what had happened to her in the past: I was no more than a visitor passing through Johannesburg, and primarily wanted to find out what could be done with regard to her current problems. I asked: "What can you tell me about your situation?"

Although she had appeared composed to start with, this question triggered a long period of silence, during which L. began to weep. It took a long time of gentle encouragements from

[2] At this time, farm occupations were the party's one big electioneering tool, and gangs like the one that raped L. and her friends were beyond the reach of the law, even for murder, because they were "taking back the land".

myself and her friend for her to relax. Via a conversation about her day-to-day needs, her mind eventually wandered back to her home in Zimbabwe. She worried about the availability of food there – did her grandmother and siblings starve?

From this, her thoughts meandered on to the story of her abduction and rape which she then retold. Although she cried bitterly and several times found it difficult to continue, she clearly wanted me to hear her out. She expressed anger towards the perpetrators, feelings of hopelessness and helplessness, and of embarrassment on her side. Regarding the present, she complained of difficulties in falling asleep, of nightmares in which she saw men with knives who wanted to rape her, and of getting scared when alone. She mentioned that she could not trust men anymore, and that she frequently contemplated suicide. Her summary statement was: "I sometimes think it would be better if I were no longer alive."

Our session lasted for more than two hours. As I understood that her suicidal thoughts were also related to fear of HIV, I promised getting the necessary tests on their way (she knows by now that she is HIV negative). Realising her concern about her siblings, I ended our session by making a promise and by asking her for one: I would let somebody look into the situation back home, and provide food if needed; I described her concern as proof to me that she cared for her siblings and granny and that she knew they needed her; I asked her to talk aloud to the particularly loved youngest sister, as if she sat in front of her right there and then, and to assure her that she would not desert her. L. did this with tears in her eyes.

Discussion

I have deliberately chosen to present a case example that is not typical of the majority of our cases, but that may serve to bring out something which is, in my view, typical of our work: for most torture victims whom we see, psychological issues do not play as central a role as they did for L.; all the same, in all our casework, our approach is strongly influenced by psychotherapeutic considerations.

Very frequently with victims of current torture in Zimbabwe, psychological morbidity – anxiety, hypervigilance, depressive moods, self-destructive thoughts and behaviour – is not a prominent part of the story as our clients tell it. The overarching category that encompasses their entire torture experience might be called "having been wronged". When so asked, clients will readily distinguish between bodily harm, mental anguish, destruction of property, the injustice of it all, etc. But "having been wronged" (as a summary description of what is troubling them) demands "setting things right again" as a first and most appropriate response – not, primarily or even solely, medication, physiotherapy, or psychotherapy. This does not imply the irrelevance of medical interventions: rather, replacing a burnt-down door; recording a sworn statement in anticipation of future legal action; or taking x-rays and applying a plaster of Paris for a broken bone may be three equally relevant components in an interaction that aims at rectifying a bad life experience to the extent possible.

When compared, the trauma concept and that of "having been wronged" differ in interesting ways. The former, as used in the PTSD construct, has been purged of all content beyond the formal characteristic of being something extremely damaging. No

matter how many examples are given, the DSM speaks in the end of a "stressor … of an extreme (i.e. life-threatening) nature" (American Psychiatric Association, DSM-IV, 1995, p.438). Having been wronged, by contrast, may describe something minor or something very grave; it has a moral dimension (why was what happened not right?) and an interactional one (only others endowed with reason – gods or humans – can wrong me; earthquakes cannot); it asks for a detailed description of what happened and, separately, of what this did to the victim. To me, both as a human rights activist and as a therapist, this seems preferable to a theoretical frame which, through the highly abstract definition of its subject matter, robs the torture experience of its moral and interactional dimensions to make it indistinguishable from e.g. exposure to an earthquake. Likewise, I consider the lack of distinction between external events and inner reactions to them, which is characteristic of the trauma discourse, as highly problematic: events no longer trigger responses in somebody's mind, i.e. they are not traumatogenic (if that should be the case), but traumatic.[3] Whilst on the somatic side, the distinction between the bullet and the wound remains clear, on the psychological side, the description of a possible psychic response has oozed into the description of the material world itself: there is semantic confusion of trauma as psychic damage in a victim and of trauma as the external cause thereof.

The torture experience never was a medical one, so it will be an ill-advised health worker who attempts to medicalise it. Similarly, much talking needs to be done, and psychotherapists may with justification perceive this as therapeutic in its own right. A good number of meetings with the client and, depending on circumstances, with family, friends and comrades, and traditional figures of authority are needed to record the torture story, determine its use for advocacy purposes, explore the legal side of things, attend to material damage and bodily harm and chart a way forward as regards family, security, work, food – i.e. for the entire life of the client after torture. Taken together, this amounts to hours and hours of talking. Still, to our clients the relevant category that describes their torture experience will remain "having been wronged", and thus our interventions will foremost fall under a heading that may be called "help to set things right again as far as circumstances permit" – the talking that has to be done remains a means to this end and hardly ever develops a life of its own as a "talking cure".

If what we would call genuinely psychological issues are a part of our clients' problems, they are in the overwhelming majority of cases, both in our view and in their self-perception, a direct result of the torture experience, and amenable to the multi-faceted interventions just described.

What we may call the psychotherapeutic component of our interaction would thus be regarded as peripheral or even go entirely unnoticed in our clients' own assessment. We deal here with a different way of categorising the torture experience and the reaction to it. The situation is thus not unlike the case of the murdered and improperly buried of the Gukurahundi era. Back then, in the mid-eighties, thousands were killed in Matabeleland in a government effort to create a one party state. Surviving relatives often had to bury their dead in shallow or mass graves under humiliating circumstances and without adherence to

[3] Cf. the distinction between "wrongfulness" and "harmfulness" made by Rind, B., Tromovitch, P. and Bauserman, R. in *A meta-analytic examination of assumed properties of child sexual abuse using college samples*, Psychological Bulletin 124, 1998, pp. 22-53.

traditional rituals. They might be ready to describe their subsequent afflictions as "affecting the body" (e.g. backache) or "affecting the mind" (e.g. bad dreams). Still, this would be a rather irrelevant distinction according to their own criteria, one elicited by interviewers's specific way of asking. Told in their own words, the problem at hand is a spiritual one, due to a restless ancestral spirit. This diagnosis prescribes a clear way forward: rectification of a past ill (e.g. by exhumation and reburial with the attendant rites), whereupon backache and bad dreams, it is assumed, will disappear because the cause for which they were but symptoms has now been removed.

As I have said, most of our interaction with clients is strongly influenced by our professional background in psychotherapy, and without this background our work would not be possible. But, having stated this, it is also important to note that our interaction is hardly ever confined to communication about distorted patterns of communication alone. Summerfield (2005) has suggested that clients:
"may naturally appreciate an empathic, unjudgemental listener but … it might be argued that the mental health sciences have co-opted these and other facets of ordinary human solidarity and fraternity, mystifying them into technical procedures … The question here … is whether benefits may accrue from talk therapy which are specific to a particular methodology ...".

I should like to explore, under the following three headings, what light my case example and this quotation throw on each other.

1) Clients appreciate an empathic, non-judgemental listener
This is stating the obvious, an appreciation not confined to victims of torture, but true for all people who have problems and hope for help. The sentence describes, or so I hope, my interaction with L. as well as her perception of it.

2) Do benefits accrue from talk therapy which are specific to a particular methodology?
The question might make us deviate too easily into discussions about the relative merits and demerits of different forms of talk therapy; let me therefore reword: do benefits accrue from talk therapy which are specific to nothing but the methodology, so far as all talk therapies have one in common? By which I mean, do benefits accrue from deliberately confining casework to nothing but communication about communication? Here, L.'s case is both typical and atypical of our work. For virtually all our clients, our answer to this question is a clear 'no', and our work with L., typically, abounds with examples: worries about her HIV status → we organise her test; worries about her family's food supply → we promise to check (and did supply flour to L.'s grandmother and gave the granny's letter of thanks to L.); L.'s accommodation; the training course; her asylum seeking process.

Atypically, however, there is more than just an empathic, non-judgemental approach towards practical issues. Clearly, L. is suicidal, and as she does not as yet live at the same place as her friend (organising this is yet another example that belongs to the above list) and she is often alone in the crowd at her shelter. In addressing her suicidal thoughts, my focus shifts: I now narrow down to communicating with her about communication. I suggest that by killing herself she would (also) send a clear message to her family back home. Saying "I sometimes think it would be better if I were no longer alive" could be

rephrased in several ways, among them: "I feel all alone in this world", which would reflect the situation of loneliness at the shelter and of having been let down by the extended family. However, I ask her; doesn't this collide with our group's concern for her, and her concern for her siblings and granny? I try to make her acutely aware especially of this latter contradiction, to alert her to the fact that when "sometimes" she has suicidal thoughts, her abduction, rape and exile take centre stage, and her concerns about her siblings temporarily fade away. By letting her talk to her youngest sister (and by asking her to do so again whenever suicidal thoughts arise), I try to help her structure her communication with her world and to make a decision on preferences: which kind of thoughts to declare most relevant as a basis for practical decision making.

So, atypically, there is explicit communication about communication in this case, although against the backdrop of a host of practical matters approached in what was meant to be an empathic, non-judgemental way; and the question may be raised as to which extent L.'s readiness to engage in our dialogue on communication patterns was contingent upon a previous experience she had made with our team, and with me throughout our session: that her material concerns were taken seriously and jointly addressed.

In this I am reminded of Levenson's remark that interest "in the patient as a real person, rather than as a vehicle for a fantasy system, leads to what Sullivan called the 'detailed inquiry', a meticulous investigation of the patient's interactions with others, past and present, in reality, fantasy, and dreaming." (Levenson, 1987, pp. 207-214). I am also reminded of Parson who, specifically addressing work with "traumatized" clients, says: "The three dimensions of the bipersonal relationship between therapist and patient are: (1) the transference; (2) the therapeutic alliance; and (3) the 'real' relationship. Though most psychoanalytic psychotherapists view these three dimensions of treatment in the order of relative importance as listed above, my experience with traumatized patients with strong paranoid defences indicate[s] that another emphasis sequence is required; namely: (1) the 'real' relationship; (2) the therapeutic alliance; and (3) the transference." (Parson, 1986, pp. 349-75)[4].

3) The mental health sciences have co-opted these and other facets of ordinary human solidarity and fraternity, mystifying them into technical procedures

This is a complex statement. I agree that most of what happens in the interaction between our team and our clients – and most of what happened between L. and me – indeed falls under Summerfield's label of human solidarity and fraternity, rather than being a specialist (medical, psychotherapeutic or whatever else) service. But this does not mean that it can be taken for granted (as "ordinary"). As L.'s case shows, she did not find ordinary human solidarity and fraternity in her own extended family; she might likewise not find it in some counselling organisations in Zimbabwe, where cases like hers have been turned away for being "political". Ordinary human solidarity and fraternity, ordinarily, is confined to the ones with whom one agrees, and is therefore very judgemental indeed.

[4] Parson speaks of war veterans who live in security in an affluent society. In most of our clients' minds, by contrast, *Realangst* about material survival and safety from persecution prevails. I believe that because of this, Parson's logic, which he confines to but a segment of his clientele, applies almost universally in ours: affects that are related to extra-psychic determinants which impinge on most take up the place, psychodynamically, of an idiosyncratic intra-psychic condition for some.

So, much as I appreciate Summerfield's critique of the medicalisation and psychologisation of work with torture victims, I do not share his low regard for psychotherapy. This is not because I feel that it is the one service that victims of torture need mostly or even exclusively – I have tried above to argue to the contrary – but because it is one of a few kinds of professional training (others possibly being anthropology, comparative literature studies, and comparative theology[5]) that aim at understanding people within their own frame of reference.

Conclusion

I believe that our work should not be called counselling, if this is defined as a watered-down version of psychotherapy: shorter, cheaper, and easier. What we do may be called social and human rights activism, informed in its way of interacting with our clients by a professional tradition of reflecting, empathically, on the legitimacy of different ways to live in and experience the world. We are not even simply non-judgemental, but within a frame constituted by our respect for human rights and human dignity – where deep and thorough reflection is often needed to determine what to consider right and wrong – it is our firm intention to help those who are treated inhumanely. This help may also take the form of psychotherapy, but usually it does not, not even in a watered-down version. In my experience, a client with a crushed testicle after torture needs a compassionate medical doctor and a good explanation, not 'counselling'. Likewise, an African family whose murdered father's corpse was pushed into an antbear hole needs acceptance of their traditional world view: if they want to exhume and rebury him, to appease his spirit, then this is what they need help with. Their suffering cannot be represented in psychological terminology without their 'therapist' joining the perpetrators, in the sense of violating their convictions all over again.

Finally, coming back to my epigraph, Améry leaves us in no doubt about what he knew he needed: "Reduced to the positive-psychological basic content of the idea, … [it was] security."(Améry, 1999, p. 46). He even describes a time in his life, just after the war had ended, when he thought he had regained it:

"*After the collapse of the National Socialist Reich there was a brief global hour in which I was able to believe that from the bottom up everything was transformed. For a short time in those days I was able to foster the illusion that my dignity was totally restored, through my own, no matter how modest, activity in the resistance movement, through the heroic uprising in the Warsaw Ghetto, but above all through the contempt that the world showed toward those who had stripped me of my dignity*". (Améry, 1999, p. 46).

Améry thus tells us that even if his need can be described as having a "positive-psychological basic content" it is by no means through psychotherapeutic manoeuvres, but through the contempt shown toward his torturers that his dignity can be restored. Not only his shoulder joints have been mistreated, but he as a person and his convictions as a resistance fighter have been "wronged", and for healing to take place this needs to be set

[5] If there is one advantage to training in psychotherapy/psychiatry, compared to the other scientific disciplines mentioned, it is the consideration it gives to psychiatric conditions proper, such that understanding is not limitless, but is qualified: whenever a client presents after TOV, the possibility of his suffering from a pre-existing psychiatric disorder is a diagnostic option. This does not happen frequently, but we have worked with clients with whom the use of their story for advocacy purposes had to be weighed against this possibility.

right. It is not up to us, to our wishful thinking, to bring about the contempt of the whole world; what we can offer is our own contempt put to action: as human rights activism in the form of empathic, multi-faceted practical help. We provide this on the basis of a communicative competence that results from psychotherapeutic training and with a constant readiness to make communication about communication an issue in its own right, as it happened in L.'s case. In my eyes, this is what torture victims need and deserve; a cheap'n'easy version of talk therapy – 'counselling' – as a substitute for and shortcut around all this just will not do!

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II. Methodology

Family counselling in post-war Kosova

Melita Kallaba[1]

The family approach to counselling is a means both to enhance the rehabilitation process for the individual family member, as well as for the family as a whole. In Kosova the approach is particularly important due to the key role of the family in the post-war situation, and it is frequently used in combination with other interventions in the rehabilitation process.

Background

The war in Kosova from January 1998 to June 1999 heavily affected the conditions of life for the population. During the very intensive aggression from the Serbs almost 10.000 persons were killed and close to 3.000 disappeared. Massacres, torture and sexual abuse directly affected a large number of people, and more than half of the population of Kosova was forced to move away from their houses and out of Kosova. All were damaged in one way or another: on an individual level, in their family or through the damage to society as such.

The Kosova Rehabilitation Center for Torture Victims, KRCT, has directed its work towards the Kosovar-Albanian population who has been traumatised during the war. The organisation has filled in gaps where the governmental health institutions have not been able to respond. Although medical treatment has been used by KRCT, this has been combined with psycho-therapeutic support, including counselling. Thereby it has been possible not only to give medical treatment but also to help the survivors to better understand and find explanations for the possible psychological consequences after their traumatic experiences.

Traditional fundaments for counselling

With the existence of a traditional fundament for counselling, this method is not new to the Albanian population in Kosova. The reeve is an important person in community structure, who has played a role in the traditional counselling. He was an honoured person highly respected for his wisdom who used to be consulted by individuals and families for resolving different problems at a personal, family or societal level. The reeve also took part of the traditional chamber where he, together with other respected members of the community, responded to problems through a search for common solutions.

This traditional fundament is important for the counselling efforts of today. The traditional reeve seldom exists as a person today, but his role exists in a dimmed form filled out by psychologists, psychiatrists and other health professionals working in Kosovar communities today. These professionals are to a certain degree seen as new leaders who enjoy great respect from the population, even from the elderly and notwithstanding their age and gender. They are perceived as trustful, wise, visionary and as persons who are very close to the people.

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Family in a key role
KRCT has chosen the family approach to counselling as one key entrance to psycho-therapeutic support. One of the reasons for this is the traditionally strong role of the family in the Kosovar-Albanian society. The traditional family is the core of the Kosovar-Albanian society and is the most important institution for the integration of the individual in society. There is a tradition for mutual support in everyday life and in crisis situations.

Furthermore, the family has gained an increasingly important role in the war-affected Kosova where weak state institutions, including health institutions, have been unable to fulfil their functions which leaves the family with a number of additional responsibilities. The society has passed through a phase of "de-institutionalisation", which prompted revitalisation of organisational structures around traditional Albanian institutions, including the family. The schools, for example, were deinstitutionalised and replaced with house-schools. The same happened to the hospitals as well as to the cultural, artistic and political life as such.

Finally, the family approach responds well to counselling needs in Kosova. As a consequence of the war, not just individuals but whole families have been affected. Loosing family members has changed the individual family structures, and families have been supported on a whole, supporting them to identify ways to adapt to the new family situation.

Defining the approach
When defining the approach for counselling, be it at the individual, family, group or community level, the basic criteria is the problem of the client, i.e. the dimensions of the problem. If the client's problem is focused only on him/her and there are no other indicators which point towards the inclusion of the family, and if the client agrees to solve it in personal terms (for example in order to maintain confidence in relation to the family) then we decide to follow an individual rehabilitation.

However, if the problem includes other family members and disorders in family relationships then one or more family members are included in the treatment in order to support the rehabilitation process of the client. This can, for example, be cases where the client due to his psychophysical state has lost his previous function in the family. In such cases it is important to include the family in order to restructure the roles.

It is also important to consider using the family approach in cases where family members have "disappeared" or have been killed, resulting in confused and mixed up roles and functions of the family and the family members.

The inclusion of the family can also be important in cases where a client has a hidden positive potential which can play a key role in the rehabilitation process. This potential can be put into play through having family members offer their support. There are also cases where friends are included in the direct rehabilitation process, although rarely because of the fear of stigmatisation from society.
Cultural aspects of the community are also criteria to be taken into consideration when deciding whether a family approach is useful. In relation to this, it is important to carefully analyse the regional differences in Kosova. For instance, in rural areas KRCT has noticed

a greater interest from clients themselves and their families to include family members in the rehabilitation process.

The resources available can also be influential in the selection of an approach. Lack of professionals and great treatment demands of persons suffering from post-war problems has in some cases required the choice of a family approach and community treatment. The damage of buildings has lead to a lack of appropriate environment for individual therapy, which has also prompted the use of a family approach. Creating alliances with clerics (be it Catholic or Muslim) and the therapist is one way of identifying additional resources, especially in areas where religion is influential. Often, part of the support in counselling can be given by the clerics, which is both an additional support but also has a value in its own terms and which can have a very positive influence on the client.

It is important to underline that the selection of the family approach not necessarily implies the exclusion of other approaches. Sometimes the approaches are integrated depending on the moment and the level of development of client/counsellor/psychotherapist relationships and from the whole therapeutic process. For example, a period of individual counselling can be followed by a process of rehabilitation involving the family or vice-versa where the rehabilitation begins with family counselling and in the process identifies members of the family who need individual treatment.

I will present two different cases in order to give an insight into how KRCT applies the family approach to counselling.

Case # 1: Boy with adult responsibilities
A 13-year-old boy had lost his father, who was killed during the war. The boy was brought to KRCT by his mother because of bad marks in school, weight loss and sleeping problems.

The boy lives with his mother and two younger sisters. Apart from the mourning of the father he confronts other difficulties that appear as a consequence of the father's absence. At first the boy felt the absence very strongly, both in the personal and in the family life.

As the eldest child and the only male in the family he felt responsible for taking care of his mother and younger sisters. He feels compassion for his mother because she is left alone to care for the family. He therefore tries to help her in different ways with the education and care of his little sisters.

The changes in family structure have lead to role changes. Through the facilitation of KRCT these role changes and new responsibilities for the boy were discussed between him, the mother and an uncle. It was concluded that it was harmful for the boy to behave like an adult and to have the responsibilities of an adult.
The boy gradually developed an awareness of these differences and also understood how important it was for him and the family to adopt in the best possible manner to the new situation. In this way he managed to understand that it was harmful for him play the role of an adult, and the best way of helping the family would be as a good student with a good education.

The process resulted in defining that the uncle would take care of them in financial aspects, the mother would be responsible for the bringing up and the education of the children and the boy would concentrate on school, playing with friends and occasionally taking care of his little sisters.

Through the individual and family counselling we managed to help the boy and his family become aware of what they were going through. We worked with their emotions towards the stabilisation of the family roles and the best strategies for mutual support.

Case # 2: Family lacks understanding of trauma consequences
A woman approached KRCT for problems with fainting and for somatic and psychic complaints including continuous headache as well as stomach and body pain. She was constantly nervous and sensed great fear when trying to remember difficult moments during the war. She preferred to be alone and did not seek company.

Additionally, she was very distressed from the fact that her family lacked understanding of her situation or even blamed and "accused" her for her psycho-physical state. "They don't understand me, they tell me that I don't have anything", she said.

This led to her total isolation and the interruption of her communication with other members of the family. She was isolated in a room in her house, from where she rarely came out.

KRCT offered her anti-depressive medicine, as well as individual and family counselling.

In the counselling process the family members came forward saying that they could not understand her condition, since they themselves had suffered the same bad experiences as her. Based on this the family counselling focused upon psycho-education and reversion of communication between the client and the family.

Conclusion
The family approach has served as a meaningful entrance for the rehabilitation of individuals and families with traumas caused by the war. Using this approach for the counselling has been linked to the traditional use of counselling in Kosovar-Albanian communities.

Kosova is being rebuilt after the war and institutions are being reconstructed, which will reduce the number of additional functions the family has had due to the war. Still, this will not take away the premises for choosing the family approach in counselling. The family continues to be extremely important in Kosovar society, but is now confronted with new challenges. Families are under pressure, and difficult living conditions force parents to work while neglecting the caring of their children. Where the family problems dealt with by KRCT have had their origins in the war, future problems will arise from other problems, but the psychological consequences will still need treatment. Psycho-education will need to focus on issues such as understanding the sensibility of the individual and the importance of protection from the family. A healthy society needs a healthy family.

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Making traumatised Iraqi women independent through group analytic process

Belinda Labrosse[1]

A group of Iraqi women participated together in a one year group analytical treatment. The therapy was based upon the theory of basic assumptions developed by the English group analyst Wilfred Bion. The therapy supported a process where the group activity gradually became more goal-oriented. Eventually, the Iraqui women decided to establish a self-help group, which has continued after the therapy finalised.

Introduction

In March 2003, the Rehabilitation and Research Centre for Torture Victims in Copenhagen, RCT, finalised a one-year group analytic course of treatment of seven primarily and secondarily traumatised Iraqi women. The women have either been exposed to torture in Iraq themselves or are married to a torture survivor.

The aim of the course of treatment was to uncover the unconscious mechanisms in the group and thereby elucidate the psychosocial problems the women faced and together construct a process through which they to a larger extent could find solutions to these problems.

The course of treatment took place as weekly meetings over one year, during which I was responsible for facilitating this process. It was a year with very intense and sometimes dramatic meetings, which resulted in the development of a strong group that since the end of the course of treatment in 2003 has been functioning as an independent self-help group outside RCT.

In this article I will describe this course of treatment and uncover how the decisive results were achieved through group analytic work.

The client group

Therapists within the field of trauma often consider clients from the Middle East to be difficult when it comes to group therapy. This is closely related to the mistrust that characterises the clients' own experiences with their fellow citizens, as they have experienced that one may be reported to the authorities and the intelligence service possibly resulting in imprisonment and death. This is intensified for the women's part as gossip is a common social phenomenon and gives further reason for mistrust.

Somatisation is another factor which complicates treatment. It is a tendency that results from a number of problems closely bound up with each other. Amongst other things, the traditional roles in the family are put under pressure during the stay in Denmark, where the Arab women are placed in a dual role. They are expected to take care of their husband and children while society at the same time expects them to become integrated as Danish women. Within the family, however, the situation is no longer the same as the spouse is often physically and mentally broken down by the torture and is therefore not capable of

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being the patriarch and provider of the family. At the same time, the women's integration process is complicated because they are a neglected group in the healthcare system since their trauma histories are non-visible as they often come to Denmark through family reunification, which means that they do not go through the asylum phase.

Even though the woman suffers from her traumas, she is not allowed to give up her duties as a mother and wife. The patriarchal family dynamic is the one she knows and has grown up with. It is exactly through the identification with this role that she creates her image of herself since her identity is made within the cultural context in which she has grown up. For this reason it is not the best solution for her to get a divorce as it will result in a loss of identity and of the safety she feels by being who she is as an Arab woman. Furthermore, she will be expelled from the Arab community.

There is only one way out of this dilemma: to somatise. As a mental defence mechanism the women develop a social phobia on the basis of the anxiety which is provoked by torture and imprisonment combined with problems characteristic of the expatriate life. The women are in every possible way trying to protect their private life since this is the only thing they have which give them some kind of safety. Because of these circumstances, the women hide behind a smokescreen of repressions and projections both in relation to themselves and to others.

It is based on these considerations that I concluded that a group analytic approach could be a way of putting an end to this tendency.

The method: Bion's theory of basic assumptions

I chose to take point of departure in the English group analyst Wilfred Bion's observations of group dynamic processes which he used for the repatriation of English war captives during the Second World War. After the war Bion became leader of the reorganisation of the Tavistock Institute and worked for several years with his hypotheses concerning group analytic behaviour in theory and practise. Bion worked with traumatised war captives who suffered from PTSD that also makes his work interesting in relation to torture survivors.

Bion's approach takes point of departure in defining the group based on its function. A group can function in two ways: as a work group or as a basic assumption group.

The work group is the ideal and is characterised by goal orientation, awareness and experience. The basic assumption group is characterised by some unconscious and more immature assumptions: timelessness, emotionality, "as if" and the unspoken assumption. These assumptions form the basis of the groups functioning or rather dysfunction.

A group analytic course of treatment will typically try to facilitate a process through which a basic assumption group develops into a work group.

In all its simplicity and complexity, the method prescribes that the person in charge of the group uncovers the unconscious assumptions which the members of the group are subject to. This awareness is a precondition for the establishment of a work group which works in a more determined and constructive manner and which uses the experiences which are effective in achieving the goal that the group has jointly chosen. Within a group of normal functioning individuals, a group analytic process will usually lead to a work group. This is not the case when it comes to groups consisting of traumatised individuals. Due to the

vulnerable state of the group members, external and internal influences can easily bring the group back to the condition of basic assumptions. Therefore, a stable framework is important for the continuous functioning of the group.

The basic assumption group is marked by some special characteristics which often go through a sequence of phases: t*he dependency phase* is often the first to arise. During this phase, the leader is given a magic position and is assigned enormous power, strength and insight by the participants who expect him to solve all sorts of problems. Such a group constellation can be compared with a patriarchal family system in its most extreme form (Tolloczko, 1998).

The next phase which the group enters into is *pairing*. The attention of the group is fixed on something which takes place between two persons in the group. The couple represent a hope for something better to come and is a symbol of some kind of vision for the future. The role of the leader is not very significant during this phase.

The last phase, *the fight/flight phase*, is characterised by anxiety but this anxiety is often unconscious in the group and is linked to a more or less fictive enemy. The group is concentrated on fighting this enemy and the anxiety is thereby projected out of the group. The group is more occupied with a fantasy of the enemy than the actual realities. The idea of the external danger helps repress the fact that the enemy does not necessarily lie in wait outside the group but that "the dangerous" can be part of one self.

Wilfred Bion's theory of basic assumptions

	Main characteristics	Group dynamic processes
Basic assumption group	Timelessness Emotionality "As if" The unspoken assumption	Dependency Pairing Fight/flight
Work group	Goal oriented Awareness Experience	Mutual decided goal, agreed on by the group as a result of the process.

The constellation and frame of the group of women

The theory of Wilfred Bion has functioned as the basis for understanding and developing the group analytic process which I facilitated to the group of seven Iraqi traumatised women for a year. The seven women were selected for the group through qualitative interviews. They were between 30-45 years old. Five of the women were married to victims of torture while the other two lived separated from their husbands. All the women had children. All of the women came from Iraq, although one was originally from Iran. Iranians living close to the Iraqi border some times move to the Iraqi side of the border because of marriage or employment. Thereby, these people become Iraqi citizens but are looked upon as Iranians. They speak both Sorani and Arabic. Four of the group members had a high-level education while three had basic schooling. One woman was illiterate due to interrupted schooling. All group members lived on some kind of transfer income.

During the year in which the group process developed, the form of the weekly meeting was the same. The group met two hours every week. The meeting began with a body-consciousness exercise lead by an Arabic interpreter using music with panpipe and sounds from the rainforest. This exercise was succeeded by a verbal follow-up. After a break we would end the meeting with another session of group conversation lead by me. The Arabic interpreter is from Jordan. She participated in the entire meeting and knew the group of clients well.

From basic assumption group to work group
The initial phase of the sequence was marked by a certain frustration because the participants were not told exactly what the purpose of the group therapy was, but were encouraged to wait and see what would happen instead. One of the preconditions for creating a work group is that the women form the content themselves.

In the first phase of the group the need for an idealised leader soon appeared; what Bion calls the dependency phase. This need was directed at me as facilitator, and the women sought my answers to their questions. Rather than meeting this need, I chose to keep throwing the questions back into the group instead. During the first three months, the content of the conversations kept a distance to the women's own life. Instead, it concerned, for a great part of the women, their disappointment of not being met by doctors and the health system when it came to their pain and physical illness. They were often refused with the explanation that their problems were mentally determined. Since I was not willing to give them a plausible explanation of how their symptoms were connected to the mental, their frustration rose and they made me a representative for the entire unsympathetic health system. A process which emphasised how much the women needed a leader.

After 14 sessions, we experienced a breakthrough as the women began to break their silence with regard to conditions in their personal life and background. One woman spoke of her experiences with torture, which opened the way for several of the other participants telling about their primary and secondary traumas. At this meeting it was said that it was nice both laughing and crying together. One of the questions I asked the group was why they did not initiate meetings with other Arabic women themselves. One of the participants answered that it was due to lack of trust, which was a result of their bad experiences with informers in the Iraqi environment. This view divided the group in two, as another woman argued that it was necessary to take a change and open up to other people. The same woman was surprised that she – even though she spoke Danish, had a Danish education and a good network of girlfriends she could trust – still had become ill. Her surprise at this was ground-breaking to the process because the women began to see a connection between their background, traumas and current situation of life in exile. It gave them confidence to talk about the home front at a general level.

Circumstances outside the family also influenced the treatment process. This primarily concerned the foreboding war against Iraq, which caused much unrest among the participants since they all had family and friends still living in the danger zone, primarily in the big cities Baghdad and Basra.
This problem influenced the process; partly because the group did not agree on the significance of the war to the future of Iraq and partly because a point of view concerning

the regime of Saddam Hussein was demanded of me as leader and representative of the Danish population. Anger directed at me as leader and a dawning urge to revolt arouse in the group. At the same time, some of the women tried to defend me and thereby showed their dependence on me as the idealised leader.

Session no. 21 was also important to the development of the process. The conversation during this session dealt with trust and a woman, who I will call "the attacker", pointed out that not all of the women in the group had suffered equal hardships. She indicated that some Iraqis had come to Denmark for reasons of convenience. Another woman said that it had to do with the women's lack of confidence in one another, and that they therefore chose to talk about the least dangerous things, namely the general things instead of the personal things like the foreboding war in Iraq. I intervened by saying that the group represented a mini Iraq where there is no trust and where internal conflicts are played out between ethnic and religious subgroups. This resulted in a division of the group. Through interpreting the group's defences rather than the individual statements I moved the women's focus from individual to group level, while also giving them an insight into group dynamics as a destructive or constructive factor. I had thus managed to get to the heart of the matter through an intervention at group level.

Despite the breakthrough, the group was still far from becoming a work group. We were in the "fight/flight" phase, where the unconscious anxiety was projected to parts of the group and the leading couples, which had been formed in the previous phase and who had divided the group, now openly fought each other. My task became interpreting the group's collective defence in a way that raised the group's awareness of this defence. At the same time I had to avoid interpreting the behaviour of the individual group members, which would have met their infantile needs as well as constituting a risk for implicating me in the process. By giving attention to the individual group member's story, I would be nurturing the person's infantile need for acknowledgement of her individual needs, which would not necessarily coincide with the group's need for development.

At the following meeting, the atmosphere was tense. "The attacker", who now represented the group's defence, said that I had behaved in an accusing manner towards the group. I intervened again; I said that through the high expectations they had to me as the leader and all the attention directed at me they avoided talking about the mistrust that characterised their relation to one another. Afterwards the group agreed that I did not trust them. Once again I intervened and said that they were giving me the role as the "mean leader" alias Saddam Hussein and that by doing so they once again focused on something other than the anxiety they felt in relation to each other.

"The attacker" was still very angry while others started admitting that they did in fact have a lack of trust in their relations to other people. Subsequently the anxiety became more undefined and my most important task was again to raise the group's awareness at group level. The fight continued the following session. Now the group had chosen a leader, the most religious and least educated of the women, who had six older children. I was no longer of use as the one who could bring the group through the heat of battle. All anxieties was projected onto me as I now represented the external enemy whom the group could jointly fight. The women who had previously shown strength now remained passive.

I felt that I was in the middle of a sandstorm being shot at from all sides. My task was to parry the shots by intervening at group level and by resisting the temptation of becoming the caring leader.

If the women were to gain new knowledge of their own mechanisms they had to be sufficiently frustrated for them to take back responsibility to the group and to break the primitive projection. The decisive matter was that I maintained my neutral position and as formal and, most of the time, actual leader managed to get through the fight and the flight without becoming implicated. Therefore, I had to tolerate being put out of action and being bombarded with anger and mistrust from time to time. Through maintaining this position, the women would become sufficiently frustrated for them to take back responsibility to the group. This would bring the group onward, but the decisive factor in the creation of a work group was that the women gained a higher level of trust between each other when they discarded the leader.

Three months before the end of the treatment the group occasionally functioned as a work group. A good example of this was a case, where a participant broached a subject as a question addressed to me. It concerned the relation to her 8-year old son whom she had great difficulty controlling and setting limits to. I addressed the question to the group, which the woman accepted, and this started a lively debate on the bringing up of children where much cultural and psychological explanation and advice was given to the woman. The group worked in a conscious and determined manner to solve the problem, which appeared to be common to the woman who introduced the problem and to the rest of the group. Respect and tolerance was shown to other group member's views. With this atmosphere, the woman could for the first time bring up something personal, namely that she was alone with her four children. The fact that she and one other group member were divorced had been taboo up until this point. Although this statement was not remarked, it was a strong manifestation of trust that the woman felt able to share this with the others without fear of being rejected or criticised. Here, the group functioned as a reflecting work group where the women could mirror each other and meet the individual in the need for reflection, which could lead to better insight for the individual participant as well as for the group as a whole.

I announced the date of the final meeting three months before the end of the course of treatment. This had a big impact on the process, and following my suggestion, the group began preparing the formation of a self-help group. This process brought more energy to the group and several members took initiatives in leading and taking on responsibility for the continuation of the group. Words like "a new beginning" came up and my role became making a democratic creation process with regard to the self-help group. The women were themselves in charge of making the guidelines for and creating the new self-help group. The self-help group started immediately after the formal course of treatment at RCT ended and still exists today, more than two years later.

Conclusion

At RCT, we consider the group analytic course of treatment to have been successful and to have fulfilled our expectations. This assessment mainly rests on the fact that the clients have been given the possibility of finding answers to the questions they have in relation to the healthcare system through the raising of their awareness of the unconscious

mechanisms in the group which block initiative and independency. The increased independency is important amongst other things because the clients are deprived of their independency in the healthcare system because the various treatment providers give them the answers to their questions. Thus, this method provides the women with a possibility for breaking with the infantile dependency which they have brought with them from the patriarchal system with which they have grown up, and which they are currently locked in.

The fact that all the group members come from Iraq has been crucial to the process and to the group's continued existence. The group can be seen as a miniature of the Iraq of today, which is fighting to create a democratic state. The background for all the problems which Iraq encounters in this creational process can also be seen in the light of these women's cultural context and basis for living together with the group processes which take place between them.

In the self-help group which functions today, the women create a space where being a "normal" Iraqi woman is a goal in itself. As the central point of their meetings they have chosen conversations about beauty care, cooking and the role of Iraqi women in the Iraq of today (women the Iraqi way); and not, as one might have expected, the violence and the assaults which have caused their sufferings. The women have named the self-help group Qabul, meaning friendly reception, which again reflects that they have found their own meaning of what a self-help group is perceived as in the established treatment environment.

"Through their social acts of vanity and care, they attempt to become normal Iraqi women, once again" (Buch, 2005). Lotte Buch has conducted a thorough ethnographic field study which, although it does not conclude anything about Iraqi women in general, says something about the women who have chosen to continue the self-help group together. Based on research interests, a number of general questions can be asked with point of departure in the considerations Lotte Buch has made in her field study, i.e.: What brings together women with this background in a self-help group and what do they gain from the time they spend together? What does the group analytic process have to offer with regard to the development and existence of self-help groups for Iraqi women?

One thing is certain: the women have found a mutual trust, which has formed a common point of departure for their meetings. This was the goal and also became the result of the process the women's group went through, which finally resulted in a sustainable work group; in this case in the shape of a self-help group outside RCT.

In my view, Bion is a fantastic resource concerning work with people who have experienced war and torture, namely because he has developed the theory based on his own clinical observations of returned war captives. Furthermore, women from the Middle Eastern countries are still raised in very patriarchal family dynamics. This makes the method suitable as it builds on Freud's thoughts on the tendency of the individual to be subordinate to an authority and to become dependent on this authority as a consequence of being brought up in a patriarchal family. The weakness of the theory is perhaps that it is very demanding to carry through for the group therapist. The group pressure makes heavy demands with regards to the ability to stand firm, to maintain a comprehensive overview as well as having endurance concerning unpleasant feelings, which the person in charge of

the group is subject to as a necessary part of the process. At the same time I would like to stress that when the therapist is able to carry through the process in a neutral and professional manner, the result is very rewarding for the continued existence and growth of the group and especially for the job satisfaction of the therapist.

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Family, community and violence: A mental health approach from Honduras

Eliomara Lavaire[1]

Violence within the family is a product of organized violence in Honduran society. Therefore, prevention of violence needs to be approached in an integrated manner working with individuals, families and communities at the same time. A methodological approach focusing on mental health has been developed building upon involvement of community leaders and support from popular organizations.

Introduction

Through history, the indigenous and peasant population in Honduras has been victims of marginalization, discrimination and violations of their human rights. Land evictions, imprisonment, persecution, torture, social exclusion and violation of their right to life are all manifestations of this.

The organized violence and the torture is intentional, planned and within a particular ideological frame which through the creation of an environment of insecurity and terror breaks down the general self-esteem, paving the way for absolute power. It may produce serious effects in the mental health of the victims, breaking down their identity, ideals, values and their personal and collective life projects.

The violence within the family is a product of the violent societies which reinforces the creation of environments ready for oppression and social and economical injustice. The effect is not always limited to the victim. Sometimes the survivor will react consciously or unconsciously with aggression and violence to those who are in a weaker position than themselves.

Masculine authority and gender discrimination indicates women and their children as the likely victims of the victimised men's violence. In this way the family may be characterized by tensions and aggressions both in their relationship between family members and in the relationship with other families and the community, thereby closing the vicious circle.
Families among the *Lenca* population in the rural departments of Lempira, La Paz and Intibucá are permanently exposed to risk factors of violence. The *Lenca* population is estimated to 100.000 persons, living in 100 different communities in the areas of highest altitude in Honduras. The violence risk factors have caused serious damage to the mental health of the families, which has transformed into emotional damages, physical illness and inadequate management of emotions. This can lead to violent resolutions of small and big conflicts thereby creating violent environments, which limit the possibilities for a peaceful and harmonious cohabitation.

The lack of state policies for social and economic justice, integrated family treatment dealing with the problems of violence and the missing acknowledgement of when a pain or illness is a product of the state's abuse in the exercise of social control calls for alternative means to approach this situation.

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Background
The Centre for Prevention, Treatment and Rehabilitation of Torture Victims and their Families (CPTRT) has taken a mental health approach in the work with prevention and treatment of families exposed to organized violence and violence risk factors. Thereby CPTRT seeks to respond to some of the needs for treatment and prevention of violence in the Honduran society.

Within this frame, CPTRT has worked systematically with attention to the communities exposed to organized violence, and has slowly built up efforts towards this objective. The experience gained by CPTRT in its attention to torture victims and their families made it possible for the institution to approach the indigenous organizations in the country, and an agreement was established with the Civic Council of the Honduras Popular and Indigenous Organizations (COPINH). The agreement opened for increased cooperation between the two organizations and made it possible to establish new leading posts, such as the voluntary health promoters. From 1999 to 2001, thirty indigenous health promoters were trained enabling them to identify torture victims and to give these victims the attention needed or to refer them to professional treatment. Often the health promoters has functioned as multiplicators by forming health committees in their communities, sharing their knowledge and responsibility with a larger group.

At a later stage, the voluntary health promoters were linked together in a network, and strengthened in the cultural values and other different ways, for example by the establishment of two places where they could obtain basic materials for the production of natural medicine.

Pilot experience
This process led to a pilot experience attending to the indigenous and peasant community Las Limas of *Lenca* tradition aiming at the prevention of violence. The community with a total of 87 families was approached through the development of an integrated mental health process strengthening attitudes and abilities as well as enhancing relations at the individual, family and community level.
The following parties participated in this exercise: the health team from CPTRT, the health committee of the community experienced voluntary health promoters, and two promoters from the newly established network. The work developed within five different components:

Organization
The initial contact was established through the attention to victims of organized violence in the community. A visit to the community was carried out where the informal leaders were consulted regarding our intentions to develop the working experience and to make a diagnosis related to violence during the process. The proposal was accepted and the voluntary health promoters organized the establishment of the health committee, which supported the process.

The following steps were discussed as well as the criteria for selecting the families. The committee agreed to carry out home visits to identify families who had been exposed to torture and organized violence. The list of selected families was then reduced through

discussion with the community leaders, who prioritised the 13 most affected families. During the following work the community leaders were continuously informed on the development of the process.

Training
Each month a three-day visit was carried out in the community where two members of each family participated in training activities. Prior to each training session CPTRTs health promoter visited the families to follow-up on the last training session and to prepare the families for the forthcoming training session. The issues dealt with at the training sessions were torture and organized violence, differences to other types of violence, mental health, human rights, conflict management, stress management and self-confidence. Furthermore, a youth group was established which worked with issues related to mental health and prevention of violence. Drawings were used as a way of expressing sentiments and emotions.

Medical and psychological attention
Based upon interviews with persons directly affected by violence, a file was opened on each member of the family. The family members were attended to through orientation and treatment combined with both orthodox and alternative medicine. Crises and conflicts within the family were also dealt with.

Health and social promotion
This activity was directed to the community as such, for example through presentations on health and violence prevention issues. Visits to the municipality and schools were part of this component in which the voluntary health promoters and the health committee took a very active role.

Monitoring and evaluation
Indicators were constructed for monitoring health at the individual and the familiar level. At the individual level, the indicators were identified in three levels:

- Physical: pain, organic dysfunction, affected energy.
- Psychological: fear, anxiety, depression and suicidal tendencies.
- Social/familiar: Family conflicts, community conflicts, capacity building, community participation.

At the level of the family group, we identified two levels:

- Relations between the family group: communication, violence and mutual support.
- Health in the family group: common diseases, chronic and genetic infirmities and psychosomatic diseases

Individual indicators are applied to a member of the family who suffers from torture or organized violence and is a score according to the level it interferes in daily life of the person, in the scale 0, 1, 2 and 3.

Case study
A family with eleven members, whose mother and father grew up under an environment of violence and poverty. The father suffered severe punishments during his childhood and was object to torture and organized violence.

The mother had passed through similar suffering. At the age or thirteen she had her first partner and during the adolescent pregnancy she saw the killing of her father with a machete by her partner. For this reason, she became a single mother with a severe mental trauma.

At the moment of the family intervention the following problems were found: The father was marked by alcoholism, there were intra-family and domestic violence (father against his couple and children), the father was having an affair with the neighbor, who developed aggressive behavior towards the mother. The situation contributed to community conflicts. The children rejected the father.

Several health problems were present in the family: genitourinary infections, intestinal parasitism, bronchial asthma, anaemia, respiratory infections depression, anxiety, fear and intentional suicide.

The intervention of the health team was at both the individual, family and community level: they provided medical and psychological care, educational services, counseling, individual and family and group therapies, home visits and meetings on conflicts resolutions.

The initial stage of intra-family and domestic violence was measured to the highest score, but was reduced to the second highest score. As a result of our work with the families and community, the family interaction was improved, resulting in better communication, reduction of violence and better mental and physical health.

Results from the pilot phase
The case is an example of the important results which came out of the pilot experience, with the improvement of the physical and emotional health of the survivors of torture and organized violence, as well as for their families. The results included:

- Increased connections between members of the community and improved knowledge of the problems which affect the family, thus enabling the survivors and their families to redefine their strategies.
- Promotion of changes in attitude and behaviour related to violence, leading to improved mental health and inter-personal relations in the family and to the community.
- Acknowledgement of CPTRT as an institution which works for the health and human rights of violated persons.

Following the pilot experience, CPTRT planned to work with 13 new families. However, the context of violence interfered with our indicial methodology, when our team during one of the visits to the community were assaulted by armed men and kidnapped for two hours. This incident and the risk of violence made us modify the methodology

- The health team would not work directly and in a systematic manner with the families in the communities and would only carry out a limited number of visits to the communities.
- The health team would coordinate the work with the network of voluntary health promoters, thus enabling the health promoters to work directly with their communities.

Based on these changes and the experiences of the pilot experience, the following comprehensive methodology was developed and applied.

Methodological proposal
The methodological proposal has an integral vision of the family, including aspects of physical, mental, spiritual and social health. It seeks to prevent violence and its effects on mental health through the improvement of relations at family and community level. The methodology seeks to support a process where members of the community become carriers of principles and values which can generate positive changes for development at personal, family and community level.

The methodology is based on a systemic approach to the family based upon the following cross-cutting issues:

- Human rights, considered as fundamental rights which permit us to fully develop our human qualities, our intelligence, our talents and our conscience.
- Gender equality, meaning masculine and feminine roles considered in an equal manner within the family system.
- Mental health, defined as the capacity of the individual to perceive reality in an integrated manner and to construct active relations, which make possible the development of mechanisms of adaptation and transformation permitting the individual to be in harmony with itself and its surroundings.
- No violence, seen as a fundamental principle to co-habitation in an environment of respect and tolerance.
- Empowerment, defined as a strategy oriented towards increasing the confidence of the family members, enabling them to conquer power spaces permitting their development and eliminating social inequalities.

The methodology is developed within the following 5 components:

Training
Seen as a means which permits to reflect and analyse violence and related risk factors. The training is understood as a non-formal educational model oriented towards the promotion of participation of the actors in an environment of respect and horizontal communication.

The training employs methods which promote participation, develop creativity and link content with context. Brainstorming, group work and socio-drama are part of the instruments used. The elaboration of content and methods is made according to the

knowledge and understanding of each group. The issues dealt with are mental health, violence, family human rights, culture of peace, gender, and values.

Integral attention
This is a process of medical, psychological and social support, which aims at strengthening the family group to use their proper resources and to confront the effects of violence in the best possible way.

The integral attention is given in three ways:

- Attention given by the health promoters, who assist the families in problems with physical and mental health, which they can resolve through consultations and counselling at individual or family level. Alternative medicine, therapy, educational talks on health, human rights and prevention of violence are all means used by the health promoters in their work.
- Attention given by the health promoters on spontaneous demand, when health problems appear or when there is a need for counselling in a conflict situation.
- Medical-psychological attention given by the health team at CPTRT through consultations and counselling at individual or family level.

To the extent possible, the promoters support family members with health problems. When the situation demands support outside their area of expertise, they refer the family members to the nearest health centre or hospital. They may also refer specific cases to CPTRT for more integral attention, which means having more time to talk about the problems that affect them, and with greater opportunity to be listened to than usual in the entities of the State.

Promotion
This is the conjunction of actions which are carried out to inform the target groups and other actors on the effects of violence to the mental health of the family. The purpose is to generate a dialogue on the issue and to obtain support for the initiatives of the programme.

Some of the actions carried out are visits to municipal authorities, meetings with community leaders, popular organizations and health personnel at the health secretariat as well as interviews with the press. This responsibility is shared between the CPTRT health team and the voluntary health promoters.

The promoters take advantage of the meeting spaces in their communities to inform about the programme and are generally well-received. One example is the case of Delicias de San José where the promoters have been participating in municipal meetings and radio programmes presenting issues related to mental health and the prevention of violence.

Organization
This component is expected to give sustainability to the programme through the organization of volunteers as promoters or through participation in health committees which support the implementation of the programme in the selected communities.
Each community will have two voluntary promoters and a health committee. The promoters will transmit their knowledge to the members of the committee, thereby making it possible to carry out joint actions for the attention to the families.

Monitoring and evaluation
The aim of the monitoring is to detect the strengths and weaknesses during the process making it possible to make the necessary adjustments. The monitoring will look on whether the applied methodological process responds to the needs of the target group and whether the planned resources are sufficient to respond to the needs generated by the programme.
The evaluation is oriented toward the process and the results and will, amongst other things, assess to which degree the objectives have been met and identify unforeseen effects which have occurred.

Conclusion
The programme is being implemented with success and has received positive response and acceptance so far. At present, 12 communities in the departments of Lempira, Intibucá and La Paz have been organized along these lines, each with two voluntary health promoters and one health committee established. In each community between five to seven families exposed to torture and organized violence are receiving attention from the programme.

The experience has demonstrated that training of leaders needs to be done through connections to popular organizations that have credibility among the population and are seen as legitimate defenders of their interests.

We have also learnt that it is a good strategy to involve members of the community in the activities for improvement of mental health as this generates ownership, solidarity and responsibility for their own development.

The members of the communities are those who best know their fellow community members' problems, which makes their support and input highly useful. Furthermore, their involvement generates a climate of increased confidence which makes the work more efficient.

We have found that health promoters could work well as multiplicators, providing their knowledge and experience on to others, This is demonstrated to be a very important strategy in cases where the target population is large and somewhat disperse and when the organizations and institutions do not have sufficient economical and human resources.

Finally, the experience so far has demonstrated that it is very important to take the context into consideration when carrying out this work. A programme of this nature will only be stabile when we as Hondurans wake up and become aware of the terrible discrimination and humiliation we have been subject to.

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Historical resources of the Maya: An important building block for counselling in Guatemala

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The rich Mayan culture contains historical resources which are important to integrate in the work with the mental health of the populations affected by the 36-year-long civil war. The historical resources were directly targeted by the authorities knowing their importance for identity and meaning of life for the Mayan population. Resisting the attempt of elimination they are now revived in a national programme supporting the mental health of the communities affected by the organized violence.

Personal motivation

In 1997 I came to Ixcán wanting to know the life situation and the reality of the people suffering with the psychosocial effects from the political violence. I lived in two communities, Victoria 20 de Enero and Primavera, where I came to know the life of the people who had returned after the civil war. What I experienced had a great impact on me, and I decided to stay for a longer period of time in order to provide support using my background as a social psychologist.

For two years I was living with the people of Primavera, sharing their way of life, their worries, and happy moments. It was indeed a pleasure to see the great human capacity they demonstrated in helping each other. I sensed that nobody could deny collaborating with people living in solidarity, helping each other and respecting each member of the community as an important individual.

I learnt that Primavera had important models to offer for treatment of violence trauma in communities where the inhabitants take their development into their own hands, and through their values and principles have capacity to confront the effects of the war. In this process I learnt the great importance of the historical resources of the Mayan for counselling work.

Learning of historical resources

Primevera was established in February 1996 by a group of families who, in order to escape the civil war, had been living in the mountains for more than 12 years. The community, which today consists of around 250 families, is situated at the north of Guatemala, more than 400 kilometres from the capital.

The first day I came to the community a medical doctor who had been attending the community, but who was leaving, informed me about a number of patients. He had examined these patients but had not found any physical or organic reasons for their problems. He said they were suffering of emotional disturbances and indicated that it would be important to examine the emotional and psychological aspects of their problems.

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I found that the majority of these cases were men and women with a profound sadness, with dream disturbances, problems in alimentation, feelings of isolation and a lost sense of meaning of life.

After initial problems in organizing consultations outside peoples home, which did not work, I started to carry out family visits. Through this, little by little, I learnt about life in the community and about how people managed and resolved their problems. Based on the Mayan cosmovision, I discovered that among indigenous peoples' many things have a symbolic and a particular meaning. I also learnt that there were persons who knew how to remedy broken limbs, how to do massage and there were women who specialized in attention to pregnancies and births. Finally, there were counsellors, typically an elderly person, who could give advice on personal, family or community matters.

What I discovered was remains of the historical resources of the Mayan, which were still present after 36 years of war. These were resources that the authorities had tried to devaluate and eliminate during the armed conflict, since they saw that these resources gave life, meaning and confidence to the population. These persons had all been persecuted and the sacred places where they practised their spirituality had been destroyed or damaged. This had left the communities with few resources for the prevention and resolving of the psychosocial consequences of violence for the individual, family and community life.

But these resources did not disappear totally and I learnt to value them. I decided to work for the revival and promotion of the historical resources using them together with more traditional/Western approaches in an integrated treatment model.

Within this work, it is vital to regain the importance of the counsellor since this person is always present in the community to accompany psychosocial processes. Furthermore, through training in traditional/Western therapies, the counsellors can obtain an even more positive impact on the individual, family or community life.

The almost two years I lived in the community of Primavera were very important for me, and were also valuable when I was incorporated at the work of psychosocial reparation at the Human Rights Office of the Arch-Bishops of Guatemala (ODHAG).

Historical resources have been one of the most important building blocks for the programme for psychosocial reparation carried out by the Human Rights Office of the Arch-Bishops of Guatemala (ODHAG).

The programme for psychosocial reparation
The programme started in 1999 by ODHAG aims to consolidate the national capacity for the psychosocial attention and the community support to direct and indirect victims of organized violence. The work is carried out at the national level through the development of a participatory process, respecting human rights in the democratic restoration of the social networks damaged by the armed conflict.

The programme is implemented through 7 dioceses with one team for each diocese. Each team has been composed taking the intercultural and multi-ethnical context of each region

into consideration, thereby achieving the best possible identification for the local population. The teams in the regions are composed by different technical profiles, trainers and promoters. An additional selection criterion was experience with community support work and that they were active in the Catholic Church. At the central office of ODHAG a team was established to monitor, evaluate, systematize and promote the work in the regional teams.

After the teams were established training was initiated based on sharing the personal histories which had brought each person to where he or she was today. This process was followed by training dealing with issues related to the knowledge of violence and its expressions and therapies and methods to use in the support of survivors of the armed conflict. Practical work was mixed with theory and creativity and constant feedback were basic elements of this pioneering process.

It is important to note that there were team members who had experienced the conflict from different sides, including persons who had been participating in self-defence groups linked to the armed forces, as well as persons who had escaped to Mexico or the mountains to avoid war and persecution.

Sharing and inter-change between these persons, between victims and persecutors, was a strong learning experience which raised anxiety, fear and many questions. Nevertheless, it created cohesion, commitment and working spirit, thereby making the teams better equipped to accompany the healing and empowerment processes.

In these teams intervention plans are formulated securing that each person is contributing, thereby ensuring an integral approach to violence at the individual, family and community level. Each case is discussed and it is evaluated who will be the person to intervene. The results of the intervention will be fed back into the group, conclusions made and decision on follow-up taken.

Two counsellors and their work
Within the team at Primavera two counsellors – Don Antonio (who lived 12 years as a refugee in the mountains) and Don Esteban (who participated in the military organized self-defence groups) – have developed and articulated knowledge to accompany processes at the personal, family and group level.

Don Antonio has the capacity to listen and orientate on the basis of his experience and wisdom. He frequently visits the persons with problems at their homes in order to get to know their family situation and to find our which kind of support they need to be able to recover. He gives massage when necessary and offers herbal tea to calm their pain.

Don Esteban, who is of the *Q´eqchi* ethnic group, counts on credibility and respect within his ethnic group. Through his counselling he has made persons revive the traumatic event they have been through and have achieved that the persons have found more emotional balance and a more active participation in activities around their every day life.

Case story no. 1
FP is a male survivor of persecution and threats by the army. In February 1982, he was persecuted when he and his father were on their way home from their maize field. A group of soldiers stopped them accusing them of being part of the guerrilla groups and said: "Show us your compañeros" (comrades). The father responded that he did not take part of the guerrilla group. They were escorted into the mountains, while the soldiers incessantly asked: "Where are they?". FP acted as if he did not understand Spanish. "If you don't tell us, you will die", they were told repeatedly. "When I heard this", says FP, "I got very afraid, but luckily a strong rain started and so the forces of nature saved us". They were released the same night and soon after fled to Mexico where they stayed for 12 years.

When the case of FP was dealt with by the team FP had recurrent nightmares. He could not manage meeting a soldier or another person in military uniform, which would cause great fear and paralyse him. He was depressed and sick of gastritis, had sleeping problems and headaches.

Don Esteban proposed to go to the place where the traumatic event had happened and call the spirits. The ritual would be accompanied with symbolic elements which facilitated catharsis or the progression of the obsessive idea.

"I called the spirits at the very same place where the traumatic event happened in 1982. I used a small white candlelight, half an ounce of copal and bee wax to produce a soldier which symbolized the soldier. As his heart I used copal".

He placed the candlelight and the figure in exactly the same place where FP was scared by the military persons. Don Esteban took a branch and simulated that he was hitting FP, thereby making FP regress or revive the moment and express what he could not express at the original moment. Don Esteban told us that he made a prayer to Mother Nature and the Divine Creator of the Universe to "give graces for the wisdom and to ask for forgiveness and to have them to send their spirit to make possible our request for healing". He burned the copal and made gestures to express the aggressiveness. He whistled three times and said "Let's go, let's go home" three times. FP went directly to his home. Don Esteban stayed and kept praying, while covering the figure and the candle with soil. Then he went to FP's house where he continued the prayer with use of copal and candles, repeating the simulated hits with the same branch which was later thrown out.

At the next session FP was in a much better stage and grateful for the treatment. Over time he has become much better, he sleeps and eats well, the fear has disappeared and now he can tolerate being close to a uniformed military person. He is now an active member of an organized group, which is part of a national organization seeking justice for the crimes that have been committed during the armed conflict.

Case story no. 2
MJ is a woman of the ethnic group *Mam*, who today lives in the community of Pueblo Nuevo. On October 8th 1982 she and her family fled to the mountains to avoid attacks from the army. Her husband did not manage to leave and was killed. She was left behind with 8 children. MJ stayed in the mountains for two years before leaving for México, where she lived for 10 years. Her experiences have left her sad, fearful, with lack of confidence,

insecurity, low self-esteem, insomnia, nervousness, cardiac fibrillation, headaches, pains and poverty.

Don Antonio came to her house giving her time to gain confidence in him. He went through her life story and asked her how she felt now. He listened carefully giving her time to tell her story. He identified the place in the house which had a special meaning for her. He gave her massage and provided relaxation exercises.

Then he put his hands on her to transform energy while praying with a low voice with the intention of connecting to God. “Through this prayer I ask for peace and quietness for the patient and her family and community life and for this person to recover her health”, he said.

To remember her deceased husband he lit a candle, making a prayer to the Holy Earth and Holy Soil asking for her husband to rest in peace and to guide the life of the widow and her children. He called on the Earth and the Moon and the Nature for help and to give energy to the patient. “One should connect to nature, using a transparent cup, making the signal of the cross over the full cup and drink it”, he later tells us about the ritual.

He also uses flowers which he brings to the house and leaves at the special place in the house until they dry out.

After 6 work sessions with MJ she feels better both physically and mentally, and her headaches and body pains have diminished. She has integrated into the collective life of the community and participates in meetings and activities. She is in the process of identifying the body of her murdered husband through exhumations, and participates in the process through workshops and meetings conducted by Don Antonio.

Results from the programme
The local teams established by the promoters from Ixcán have shown to be a fundament for the work. It strengthens the ownership of the work at community level and the sustainability of the activities, and has worked as a successful experience for the reconstruction of the social networks. The shared Catholic identity of the team members has worked as a unifying factor in this regard.

The Mental Health Team is part of the pioneer work in mental health in the Department of Ixcán and in Guatemala as a whole, and a key actor in the mental health in the municipality, around which it is possible to formulate new initiatives related to mental health.

The beneficiaries have expressed their opinion of the programme in the following ways: “This is giving importance to talking”, taking into consideration “the existence of the problem – mental health – and the alternative forms of solution”. It favours the “participation of the population”, permitting “the knowledge of history”.

The process has also permitted “the right of the women to speak and participate”, as said by one. This is a right which has been denied them for generations. They have benefited directly by having a space for themselves: “The women feel alleviated when they cry,

when they talk of their problems, they receive massage and talk to other women, sharing", as one woman explains.

It has also been an important factor for the success of the programme that is has filled in a vacuum where no other development organization or state institution has acted. "Only the church comes there to find out what has happened. We are lost here as an animal without an owner", one inhabitant said.

Conclusion

The good results of the counselling can be explained by its origin in historical practices and the confidence which the communities have in it. Furthermore, it comes from legitimate leaders. Don Esteban says: "This work can be done even if not connected to the Pastoral Social of the Catholic Church through the confidence the community members have in the counsellor. It is almost like the confession, to listen and to give advice. The Pastoral Social of the Church in Ixcán has only come out stronger from this."

The use of local resources has found a fertile ground in the Maya culture in Ixcán in the richness of the different cultural, social, economical and political expressions.

The success of the massage is also in part explained by being a historical practice in the communities, as well as for its immediate positive effects. As Don Antonio says: "I like to give massage, since it is a very practical thing, and it gives results on an immediate basis".

In meetings with the two counsellors, both point to limitations of the use of historical resources. Don Esteban says: "I recognize the limitations and the fact that not all illness should be treated by the counsellor with cultural resources. We know where to go, and I refer the persons to others when I see my limitations."

The counsellors have obtained legitimacy and the confidence of the population due to the fact that they come out of historical practices and are recognized leaders in the communities. It is important to strengthen this good standing of the counsellors.

In Ixcán, as well as in the rest of Guatemala, the mental health work is characterized by being pioneer work which implies a great challenge: It is a model to be constructed and modified continuously. It is important to take into account the role of the moral authorities and the use of existing historical resources.

In this sense, it is a challenge to investigate and know more of the historical resources of the communities to prevent and resolve problems of mental health and to incorporate these in the counselling work.

Bridging the body and the mind: The relevance of a body-oriented approach in the counselling of survivors of torture and organized violence

Lone Tived[1]

Based on the understanding of the body and mind as integrated parts, it is important to supplement counselling of survivors of torture and organized violence with an adequate body-oriented approach. Experience with this approach has demonstrated that it can help empowering a person who has been exposed to torture or organized violence. Nevertheless, caution must be taken when adapting a body-oriented approach between different cultures.

Introduction

Today, most Western rehabilitation models are based on an understanding of the human being as an entity, where the patient's physical, social and economical history and resources are assessed as having an influence on his or her health conditions, disorders and diseases.

Still, this understanding is relatively new in the occidental health professions, where body and mind up until about the 19th century were regarded as two completely divided entities and were treated separately with psychological, physical or physiological interventions. The French philosopher René Descartes (1596-1650) was one of the persons who laid the ground for this understanding, emphasizing that thinking is an activity totally separated from the body. According to him, the brain is 'the thinking object' and the body is 'the not-thinking object', which has extensions and mechanical parts. Descartes is thought to be inspired by the development of new technologies leading to the analogy of the human body seen as a machine.

Since the beginning of the 19th century, opposing theories have challenged this idea of a division of body and mind. Two of the most conspicuous opponents to this thinking is the psychiatrist Wilhelm Reich (1897-1957), who is known for the theory that psychological problems manifest in increased muscle tension (muscle armour), and the physician Alexander Lowen (born 1910) who - inspired by Wilhelm Reich - included the body-oriented approach as an important part of the psychological treatment. Reich, Lowen and many others have influenced the treatment models and some counselling models of today within psychotherapy, psychiatry, physiotherapy.

The general understanding of the body and mind as integral parts is broadly accepted today, and this is also reflected in the definition of health by the World Health Organization (WHO), which implies seeing the human being as a whole: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1948).

Consequently, the body and mind are considered to be closely interrelated and should be treated accordingly. For example, a person who has been subject to verbal humiliation exclusively for some time will be likely to suffer from physical manifestations such as altered

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respiration, altered muscle tension, restlessness, inactivity, weakness etc. Likewise, physical abuse may lead to psychological symptoms such as anxiety, low self-esteem, etc.

Based on this understanding, it is evidently important to supplement the counselling of survivors of torture and organized violence with an adequate body-oriented approach, hereby empowering the person through working with body and mind at the same time. For this reason, it is necessary that the counsellor has basic knowledge about body functions and body language as a basis for choosing and working with a body-oriented approach.

Two treatment modalities

This understanding of integrity of body and mind has been the basis for the work carried out at the Rehabilitation and Research Centre for Torture Victims (RCT) from the very first years, for which reason physiotherapy has been an integral part of the interdisciplinary rehabilitation. The work has developed over the years and has been applied according to the treatment carried out. Personally, I base the body-oriented approach I use on two different treatment modalities. The first approach I use is rooted in physiotherapy, especially the psychosomatic physiotherapy which has been the basis for the treatment modality called Body Awareness Therapy (BAT). The second treatment modality is based on bodynamic psychotherapy.

The Body Awareness Therapy is often used in the Scandinavian countries for treating patients with chronic pain conditions. In this modality movements, breathing and body awareness are used to restore balance and freedom in movement, emphasizing the resources of the body as a whole instead of concentrating on body parts where symptoms are present.

The second body-oriented approach has its basis in bodynamic psychotherapy. It is based on the theory that each muscle has a psychological theme, which stays in the muscle throughout the entire life, and that body and mind are closely interrelated and therefore should be worked with at the same time. For example, if a person has difficulties in setting boundaries, for example in saying ‘no’ when this is actually what he or she wants to say, then the issue should be worked with psychologically through conversation and also by strengthening the specific muscles which are related to the theme of setting boundaries.

This approach is based on the understanding that the body ‘remembers’, and that all what has happened in a person’s life is ‘printed’ in the body and influences body posture, facial expressions, respiration, tone of voice, muscle tension, way of moving, etc.

These two treatment modalities have both showed appropriate in counselling, and they have formed the basis for the counselling I have been involved in at RCT with torture survivors residing in Denmark, as well as for activities with training counsellors at RCT partners in Guatemala and Kosovo. My use of these two modalities has been combined with practical experience from a number of counselling trainers connected to RCT and the International Rehabilitation Council for Torture Victims.

The use of a body-oriented approach in treatment, counselling and training of counsellors has led to knowledge, which has guided RCT in the development of counselling and which might inspire others to do likewise.

Reading body language

For the successful application of a body-oriented approach in counselling, it is fundamental to be able to read and interpret a person's body language (the non-verbal communication).

When you look at a person's appearance you will have ideas about his or her mood: is he or she feeling well, tired, in pain, safe, frightened, etc. While analysing a person's body language, it is important not to draw rash conclusions as each of us may interpret body language differently based on our experiences and senses. Eyes wide open could be evaluated as a result of fear, curiosity, surprise, anger, etc. Therefore, we need various kinds of impressions of the person's body language for a meaningful interpretation.

A person's body language does not always correspond to the verbal language. Most of us will have experienced how confusing it is to communicate with somebody when the verbal expression is not in accordance with the non-verbal expression, the body language. In such cases it is most likely the body language one should trust.

Another important point to consider when reading the body language is possible cultural differences. For example, a Japanese usually does not show anger in front of a stranger. Another example is that people from Southern European countries tend to have a much more animated body language than people from Scandinavian countries. They speak faster, louder and gesticulate more when talking, and someone coming from let us say Denmark could very well interpret this as an argument when evaluating their body language.

However, the elements of the body language presented below have been found across cultures worldwide.

Facial expression

The face can be without expression if the person is sad or depressed. If the person is in a good mood or is angry, it shows in the facial muscles in different ways, especially around the mouth and the eyes (e.g. a smiling face or a face contracted in anger, dependent on which facial muscles are contracted). The expression of the eyes is also part of the conclusion of body reading. The eyes can be shining with eagerness and joy, they can be piercing with anger or with curiosity, or they can look sad, all depending on which of the facial muscles around the eyes are contracted, etc.

Respiration

The respiration is sensitive to a person's psychological state of mind. When a person is feeling comfortable, the respiration usually takes place with a small part in the chest wall and with a greater part in the abdomen and it is free and profound. If the person is feeling uncomfortable, for example if he or she is nervous or anxious, the respiration usually takes place mostly in the upper part of the chest wall and hardly in the abdomen.

The respiration influences the tone of voice. When a person is feeling well, the tone of voice can be strong and melodious. When feeling uncomfortable, the tone of voice can be weak and monotonous.

Body posture
When a person is feeling well, the body posture may be well balanced in an upright and 'straight' position (with an adequate muscle tension). At other times the body posture may be too straight (with an increased muscle tension), when wanting to be in control, or the body posture may be forward declined (with a decreased muscle tension) signalling 'giving up', when feeling sad or depressed - and all the variations in between.

Grounded/not grounded
To be grounded is another way of saying that a person has his or her feet on the ground, that he or she is rooted in the earth. It can also be extended to mean that a person knows where he or she stands and therefore knows that he or she is 'somebody'. These qualities are lacking in the person who is 'up in the air' or in his head instead of on his feet.

A well-grounded person is well-balanced and relaxed, whether standing, sitting or lying, and has good contact to the foundation. An example of a well-grounded sitting position is when the person has good contact between the soles of his or her feet and the ground and uses most of the seat (and the back of the chair) to support his or her body weight. This position signals 'a feeling of belonging – a sense of security'.

If the person is not well-grounded he or she may be sitting at the edge of the chair with little contact between the soles of his or her feet and the ground, due to a feeling of uncomfort and insecurity.

However, a person can be 'too heavily grounded', which means that the energy is withheld in the body and that the person feels a lack of energy.

Movements
Movements are evaluated in relation to how rapid or slow they are, whether the movements are harmonic, whether they are abrupt or poorly balanced and through all the variations in between. Movements influence emotions in the way that a person who is feeling comfortable/happy moves in an easy, maybe quick way, while a sad/depressed person usually moves more heavily/slowly.

Applying the body-oriented approach in individual counselling
Reading the body language is the key for defining how the body-oriented approach should be applied. There are a number of exercises and other tools for the application of the body-oriented approach to counselling. Instead of listing such tools, I have chosen to present a case which illustrates how I use a body-oriented approach in counselling.

The case is a 40-year-old man from a Middle Eastern country living in Denmark. This person was suffering from PTSD, pain in the neck, in the shoulders and in the lower back. He was not able to maintain a permanent job because he often had outburst of anger when he was in close contact with other people. He was referred for interdisciplinary rehabilitation. During my counselling sessions with him I read his body language, and from time to time I gave him feedback on what I saw:

He used to sit on the edge of the chair with a somewhat declined posture (with his shoulders protracted). His respiration was seen mostly in the upper part of his chest wall and he spoke

with a weak voice. I interpreted this as a withheld energy pattern, which most likely was a result of his anxiety and depression.

I let him try out a position where he was sitting with the soles of his feet in good contact with the ground and his body in a more upright position and all the way back in the seat, so that his body was well-supported (a well-grounded position). I asked him how he felt sitting in this position. He answered that it was actually more comfortable. In addition to this his breathing became more profound and he was able to talk louder.

I explained to him how body and mind affect each other and how awareness and exercises could improve inadequate patterns, which had been developed from anxiety in order to overcome the situation. As he was no longer in an anxious situation, it was time for him to adapt his body reactions to the actual life conditions. I instructed him in a well-grounded sitting position with awareness of respiration and muscle tension in order to make him relax and experience a sense of security.

At a later occasion, he was talking about the difficulties he had in general with taking initiative. Even coming for treatment was difficult to overcome, I was told. He always felt sad and tired. I told him that TOV[2] victims very often felt this way as a result of depression. I explained him the theory of how emotions influence motions and vice versa, i.e. a person who is sad most often moves slowly and with little energy, and a person who is feeling well is able to move in a light and energetic manner. A way of actively helping himself to get through his depression was to change his way of moving into a more energetic way, which would most likely influence his mood in a positive way.

The awareness of muscle tension was another aspect we worked on. When he was anxious he often sat with his shoulders slightly raised and with tensed flexion in his elbows without being aware of this. He told me that these tense muscles often were painful and that he had difficulties in relaxing when sleeping. Trying out relaxation exercises for the shoulders and the arms – and finally for the whole body – provided him with a useful tool to gaining a more relaxed sleep and to reducing pain in the shoulders.

Finally, we worked with one of his most serious problems, his outbursts of anger. I asked him to recall any particular reactions in his body he might have experienced just before his outbursts of anger. He explained that he suddenly felt warmth in his body, his hands started trembling and he could hardly breathe. It all happened very fast and he felt as if he was going to explode. He had two different reaction patterns. One was to shout and hit something or somebody. The other was to leave.

My advice was to learn to become aware of the very first bodily signs. If he considered that he probably would not be able to solve the situation peacefully, then he should leave before he reached the stage of uncontrollable outbursts. He was encouraged to do some kind of physical activity after leaving in order to release the accumulated energy in a constructive way.

[2] Torture and Organized Violence.

Subsequently, I often had to remind him of most of the exercises in order for him to continue carrying them out. This is a well-known situation, since it often is difficult to change a pattern which has persisted for a long time and has become fixated.

After some time, he told me that he had noticed some improvement which influenced his daily life. Now it was easier for him to talk with other people when wanting to. He did not feel quite as shy and depressed as he used to. In addition, he had managed some difficult situations without hitting something or somebody.

In some situations when he felt restless or nervous he remembered to use grounding exercises and to be aware of his respiration, both of which gave him a feeling of empowerment. However, when he finished at RCT, he was very well aware that he still had to work with his reactions in order to gain more control.

Planning counselling programmes

Finally, a short comment on three issues which I find important to consider when counselling programmes and training of counsellors are being carried out. They all relate to the often-heard criticism that health professionals from countries providing support and technical advice use their own methodologies without due consideration and adaption to the context of the country in which new programmes are being set up.

While professionals treating victims of torture and organized violence often have a background in health education, the counsellor might not necessarily have an education in this field. There is often great variation in the health educational background of the counsellor trainees. Consequently, it is possible that the counsellor's knowledge of health and of the body as such is limited. This does not imply that the counsellor should not integrate a body-oriented approach, but rather that the counsellor must carry out this integration using basic knowledge of the body-mind relation. Therefore, when training counsellors, it is important to assess the knowledge among the counsellors on this matter, and to apply the appropriate pedagogy. Local advisors are often key persons for obtaining this information.

The cultural differences between counsellor trainer and trainees are important to take into consideration in the training of counsellors. If the trainer is from the West it is important to define how the Western understanding of the relationship between body and mind relate to the way other cultures see this relation. Such differences are relevant to consider when developing counselling models which should lead to the elaboration of adapted programmes tailor-made to the particular cultural context. Again, it is very important to rely on local sources for the formulation of such programmes.

The final argument for not copying programmes from one country to another is the fact that counselling is carried out very differently due to the different conditions in each country. These differences relate to the health professional tradition, the socio-cultural context, the history, etc. in each country. For this reason, it is necessary to adapt the counselling model to the given conditions.

Conclusion

In this article it is recommended to include the body-oriented approach in counselling in order to incorporate the understanding of body and mind as interrelated.. This is based on theories

from the beginning of the 19th century, by Wilhelm Reich and Alexander Lowen among others, which have influenced many treatment modalities ever since.

Today, interdisciplinary treatment models are preferred, if resources allow for it, in order to treat the patient as an entity where the psychological, physical and social needs are believed to have an influence on the patient's health conditions. In many countries counselling is the only treatment offered because of lack of resources, and therefore it is especially important that the counselling includes the body-oriented approach as an empowering tool.

However, it has to be taken into consideration that counsellors have different educational backgrounds, come from different cultures and work under different circumstances and conditions. Consequently, the body-oriented approach should be adapted to the culture and traditions of the country in question. This is of importance to the considerations of how one can use experiences from one country to another, as for example when RCT prepares counselling training.

Considering cultural differences implies that the counsellor training programmes should be developed in close collaboration with local advisors. This way, the counselling training can incorporate knowledge of the cultural background of the people it will be offered to.

The experiences so far have pointed out a number of shortcomings and demands for further work and development of this area. First of all, it is important to develop a systematic approach to analyse and describe the relation between body and mind in the various cultures where counselling is offered. Such analysis can serve as a platform for the development of modalities for the body-oriented approach in different cultures.

When the development of body-oriented counselling programmes include interaction, and for example technical advice and input from other countries, it is also important to develop a systematic approach for the understanding of the inter-relation between the two culturally different body-mind relations and possible consequences for training programmes.

The actual work with the body-oriented approach also calls for research on the effects of these efforts. For example, it would be important to evaluate whether there are any noticeable differences in the effect of individual counselling when it is given with or without using the body-oriented approach.

Finally, the field also calls for development of methodological approaches. An important area to look into is whether the body-oriented approach is adequate for a variety of applications such as individual counselling, family counselling, group counselling and community counselling as well as for the development of specific methodologies for each variety.

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Designing counselling support service in victims' associations in Bangladesh

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Promoting the establishment of victims' associations is an innovative tool for combating torture and for rehabilitating torture victims. Linking these associations with counselling services strengthen the outreach facilities for torture victims. This perspective creates a society where communities proactively rehabilitate torture victims and encourages the state to respect democracy and human rights.

Introduction

Establishing the freedom from torture and cruel, inhuman and degrading treatment for every citizen of the world is the single most important challenge for humanity today. While torture performed by state law-enforcing agencies exists as a phenomenon throughout the world, it is seen in its most cruel form in countries like Bangladesh. Communities in such countries live with the stirring stories of torture survivors. These stories tell not only the trauma of the victims themselves, but also how the communities transform such trauma and the traumatized into everyday life.

A survivor of torture inflicted by state agencies hardly survives socially, economically, and politically. Torture inflicts as much socio-economic damage on a person as it inflicts physical and mental damages. As soon as an individual is arrested and receives ill treatment from any of the state agencies, society immediately ostracises the person. Such persons, helpless and humiliated, loose self-esteem, become socially and politically disempowered as well as economically handicapped.

Bangladesh Rehabilitation Centre for Trauma victims (BRCT) is a health based human rights organization, established in 1992, which sees rehabilitation as a process of complete reintegration of torture victims into their own communities. BRCT, a pioneer health and counselling-based rehabilitation organization, has been providing treatment for torture victims for more than a decade and has, as part of its rehabilitation approach, assisted in the formation of victims' associations. There are at least 40 victims' associations, which are actively working at the community level acting both as mediators of rehabilitation and nuclei of a nation-wide prevention network operated by BRCT. Formed as self-help, economically self-sustainable associations exclusively for victims of state torture, each of the associations also refers new victims to hospitals and, most importantly, to BRCT and its mobile treatment clinic. The associations also make referrals to local non-governmental organizations (NGOs) and other network organizations of BRCT.

Victims' associations are created on the conviction that merely medical treatment or a package of medical, psychological, and physiotherapeutic treatment can only help victims recover from their medical condition alone. This is hardly enough for the victims who often

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face the much harder challenges of getting reintegrated into their own community. Thus, any attempt to rehabilitate torture survivors can only be successful if, along with regaining their lost health, it brings back the dignity, the citizenship rights (that the victim used to enjoy before being arrested and tortured) and the socio-political strength that the victim lost due to arrest or torture by state agencies. Counselling must play a crucial role in such attempts. BRCT argues that victims' associations play a vital role in the attempts from the civil society intended to offer comprehensive rehabilitation, prevention and reparation of torture, especially the torture performed by state law-enforcement agencies.

This article is designed to provide descriptive information about victims' associations. Looking at the victims' associations from a counsellor's perspective, the article explores how counselling plays an important role in the formation and the working of these associations. The more than 40 victims' associations in the BRCT-network are emerging associations with the provision of counselling support services as one of their strongest potentials.

The process of establishing victims' associations

BRCT uses an integrated rehabilitation approach to treat torture survivors. Traditionally, this approach is understood in terms of a multidisciplinary or multi-professional support system (medical treatment, psychotherapy, physiotherapy, legal services, social reintegration, psychosocial support and social counselling) providing support to the torture survivors (IRCT, 2005). However, such definitions are too broad and centralized to for patients who have survived trauma inflicted by the law-enforcing agencies of the state.

BRCT provides treatment to victims, who are then motivated by a cadre of counsellors to form victims' associations. Once united, it is believed, the victims are able to strengthen their ability to cope up with traumas as caused from state violence. Such an approach, therefore, is based on the assumption that mere therapeutic intervention is not enough for the traumatized, since torture of such nature not only imposes on the victim a serious injury or shock to body and long lasting substantial emotional wound on his or her psychological development. It (torture) also inflicts on the victims much serious socio-economic damages. A person who has managed to outlive state sponsored torture hardly survives socially, economically, and politically: as soon as an individual get arrested and tortured by any of the state agencies, society supplements by branding him abnormal (criminal, paralyzed, neurotic, or queer personality) and thereby immediately ostracisizing the person from the community. The person, helpless and humiliated, thus, looses self-esteem and become socially and politically disempowered as well as economically handicapped. He has yet to survive; medical and psychotherapeutic intervention, even if largely successful, cannot turn his condition of victimization to the state of a survivor. Therefore is the belief that victims association opens up for the victim a process of social, economic as well as political (citizenship and other rights) process of reintegration into the wider community, a necessary process that complements all efforts to provide optimum rehabilitation of the victim. Because of active participation in such a process, the victim gradually ascends from his condition of victim to the state of a survivor when they regain their lost health (psychosomatic) as well as kidnapped dignity.

Consequently, in such an extended integrated rehabilitation approach, rehabilitation is also a process of reintegrating the torture victims into their own community in the form of victims

associations. Moreover, this meaning of rehabilitation establishes a close nexus with prevention of torture in the same community. A victims association does not only assures the victim members reintegration supports necessary to survive into their own community, it also unleashes a process whereby s/he becomes the champion of human rights in the community. Being an active human rights defender, besides making a shield for himself against further state violence and torture, s/he becomes an agent an agent of prevention of torture in his/her community.

Victims associations can help new victims get treatment either from local government, non-governmental health facilities or from BRCT. Acting both as media of rehabilitation and nuclei of a nation-wide prevention network operated by BRCT, each of the victims' associations can serve as a referring institution referring any approaching new victim to hospitals, BRCT and its mobile treatment clinic, to other member organization of the BRCT-network or to local NGOs.

Furthermore, united and running a self-sustainable independent organization, the victims will be able to strengthen their economic base through operating a common pool of funds helping them not to be treated as disabled and socially ostracized in their community. They will reassert their existence in the community and reclaim their lost rights and dignity.

Besides providing regular counselling treatments, the counsellors at BRCT motivate victims to organize with other victims of similar injustices in their respective communities. However, since many victims reside in remote areas the counsellor cannot ensure that victims, once they have left the centre, actually form such organizations. For this reason BRCT's regional counsellors, with the help of local contact persons, play an important role in the formation of victims' associations.

These contact persons are acquaintances of BRCT, who, somehow have knowledge about the Centre's community level health service. They bring torture survivors either to BRCT at Dhaka or to the mobile treatment clinics that reach communities on a regular basis to provide health services to the victims of torture. Later, offering their active support, regional counsellors encourage the victim(s) to get organized with other victims from the same community or from congruent communities in an association.

Another important job of the regional counsellors is organizing professionals (doctors, lawyers, journalist, political leaders etc.) to form taskforces against torture at district level and to motivate local health professionals to participate in BRCT's local rehabilitation teams.

These taskforces and local rehabilitation teams operate locally both as rehabilitation and prevention mechanisms of torture. Once a victims' association is formed, the regional counsellor brings it into the BRCT-network through the local rehabilitation team. The regional counsellor also helps the association to get registered as a civil association, to conduct publicity campaigns for the association and to build relations to local governments. Although a significant part of the regional counsellors' job is organizing and networking, they are counsellors by profession and training. Activism lies at the very core of such counselling profession.

How victims' associations work

There are about 40 victims' associations operating in the rural areas of eight districts of the Khulna Division in Bangladesh. An average association has 15 members, who are mostly from the lower socioeconomic layer of the society. Although there are four victims' associations (two in Meherpur, one in Narail, and one in Khulna district) where the number of female members is much higher than the number of male members, the associations are normally mainly composed of males, since torture more often is inflicted upon men in Bangladesh.

At the date of its formation, a typical victims' association receives a sum of money (equivalent to USD 200) from BRCT. Subsequently, the association generates its own funding, through each member contributing to a common fund with monthly subscription fees (the average fees is equivalent to two thirds of a dollar). After a certain period, when the common fund reaches a sizable sum, they invest the money in various income generating projects such as fisheries, poultry, and irrigation. The associations also provide small business loans to the members and relatives of the members. Every victims' association is registered as required by law.

Almost all of the associations have monthly meetings where, besides regular organizational issues, they discuss personal, social and political problems and challenges. The members share their common experiences, stories of sufferings and feelings. They support each other using whatever resources available to them. Thus, they engage in a process of collective healing and regaining of social dignity.

BRCT's regional counsellors visit each of the associations on a regular basis and educate them about the basic human rights and other constitutional rights that they are entitled to. They are encouraged to observe special international days such as the United Nations' international day in support of victims of torture (June 26th) and the International Human Rights Day (December 10th). Observance of such days does not only help the victims improve their self-esteem by demonstrating their social existence, but also educates the community as a whole.

Victims are also kept informed about the jurisdictions of different agencies of the state, especially the law-enforcing agencies. Such awareness and training empowers them to address and challenge the issues of social stigmatisation and helps them gain the strength to be able to resist further ill treatment and degrading actions by members of law-enforcing agencies.

The associations also bring new victims as well as victims who have not yet been reached in contact with BRCT and its network organizations. In a number of cases the members of the association have shown the courage to bring police perpetrators to justice by appealing to the higher authorities and complaining about ill treatment. This happened in an association in Gangni Upazilla, Meherpur district, where the association mobilized local public opinion against an illegal police arrest of three people and finally got the victims released from custody. They also arranged treatment for the victims who were seriously injured due to beatings inflicted under police custody and referred the victims to BRCT. Victims' associations also help their members gain the ability to take responsibility of their

own life situation. United they face their financial, social or other problems and stand by each other during medical, psychosocial and economic hardship.

Counselling and victims' associations

Counselling focuses on helping people use existing resources to better cope with life (Tyler, 1961). It involves empathetic understanding, respect for the client's potentials to lead his or her own life and congruence or genuineness (Nelson-Jones, 1995). BRCT wants to support victims to cope better through using their local resources. Providing counselling at a centre can in part cater for this need, but BRCT plans to complement this service by building counselling support services in the communities. There are many reasons behind this decision.

First, victims often reside in the remote communities up to more than 300 kilometres away from Dhaka, the capital of Bangladesh. This distance delays the provision of treatment and creates a large time gap between the first and the subsequent sessions. Second, victims are unfamiliar with the urban environment and counsellors are not always familiar with the living and working environment of the victims. Third, the health care delivery system in Bangladesh is very poor, counselling or psychotherapy have hardly reached the rural communities in Bangladesh and subsequently professionals are overloaded with the huge number of victims. Fourth, travelling long distances is costly as well as time consuming

BRCT plans to design counselling support service in the community through providing counselling training to nominated members of the victims' associations. The nominated members are young and energetic, socially accepted, have some formal education (secondary school if possible) and they are willing to serve other victims.

These members are chosen because BRCT believes that they will be able to understand the pain of the victims as they are victims themselves. As these members are community residents it will be quite easy for torture survivors to gain access to services immediately after torture and to make frequent use of the service they need thereafter.

The chosen members will be assigned to provide this service for other members of the association as well as for new victims. In order to be able to provide this service, they will be given training in some basic counselling skills: active listening, effective communication, the development and demonstration of trust and respect, providing emotional support, explaining the reasons for symptoms and teaching relaxation and adaptive coping strategies etc.

As people in Bangladesh are generally not familiar with mental problems and counselling, BRCT believes that they feel more comfortable talking about physical or other problems. So besides specific training on psychological counselling, there will be training in basic human rights, primary health care, legal rights and basic physiotherapeutic skills. Given such training they will be able to provide immediate counselling support, basic physiotherapy and basic education regarding human rights, primary health care and legal rights.

The counsellors will be organized in two groups with two different functions: community health workers and community health assistants. While both will work in the community,

the health workers will refer to the health assistants if facing any difficulties. The health assistants can then refer serious cases to BRCT or BRCT network professionals.

Designing these counselling support services in the victims' associations will help the victims reintegrate into society with dignity and mental strength and to be able to help them solve problems according to their resources.

Challenges

The victims' associations appear to be a promising rehabilitation and prevention tool for combating torture at community level. The members recognize that they are not alone because they can share their experiences with and get support from each other. Victims can help each other both individually and collectively in solving their psychosocial, financial or other problems. Victims become more aware of their rights and the laws affecting them and can raise awareness of torture and human rights amongst people in their society. Nevertheless, this potential might meet resistance, in particular from state authorities who may threaten members of the associations or place legal constraints on their work.

Using the associations as a basis for identifying persons who after training can fill functions as community health workers and community health assistants is also a promising perspective. Through training, they can identify mental health problems of the victims and after providing emotional support, they can refer the victims for further services. Still, it is a challenge to ensure that they make proper diagnostics, referring the severe cases to the professionals and not giving false hope of cure. It will also be a challenge to keep these persons connected to the rehabilitation of torture victims, as they may be tempted to change jobs and drop out of the victims' association after having received training.

Besides the challenges of sustainability of the victims associations (as basis for community level health services) and the potential problem of retention of the community health workers, there is a further challenge of retraumatization of the workers and assistants themselves. These workers and assistants, being torture survivors themselves, may risk retraumatization from constant exposure to new torture cases. However, BRCT is seeking to avoid retraumatization by informing community health workers and assistants about how to overcome and prevent this potential complexity of re-traumatization. Peer supervision is one of the techniques promoted and trained by the organisation.

Conclusion

In BRCT, counselling plays a very important role in rehabilitating the torture victims. While the centre's in-house counselling facility is successfully helping torture victims reintegrate into their community, it can not ensure that each and every citizen of the country who becomes a victim receives the benefit of counselling. This article proposes that counselling support services can be installed in the victims' associations and thereby make these associations a counselling tool for the community. Imagine the possibility of creating a society where communities proactively rehabilitate the members who have been tortured by the state agencies. This will over time undermine the authority of the perpetrators and promote a democratic development.

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III. Cases

Exploring integrative counselling in a multicultural context: The practice of Western notions of psychology and culture-based local healing practices in conflict-affected communities in Mindanao, Philippines

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Two case studies demonstrate counselling in multi-ethnic communities devastated by armed conflict carried out by the Research and Development Programme Balay at the Philippines. Therapeutic techniques are combined with local social practices and indigenous rituals in the community. The aim is to establish an interaction in a mutual helping process on the individual, family, group and community level. It is stressed that psychological and social responses should always consider the socio-cultural dynamics. Therefore, concepts, values and practices derived from other countries should be adapted to the local context.

Introduction

People in many parts of the Philippines have experienced repeated episodes of armed conflict and human rights violations. In Mindanao for instance, the second biggest island in the country, thousands of civilians live through and suffer violence and recurring displacements due to war, militarization and deprivation. Recent events in 2000-2003 have caused hundreds of thousands of civilians to be uprooted from their familiar neighborhood and farms due to fighting between government troops and different kinds of rebel formations, particularly communists and the separatist Islamic movements. At the heart of the conflict are disputes related to issues of discrimination, social exclusions and oppression. Among the stakeholders and the victims of the conflicts are various groups of peoples belonging to at least three dozen ethno-linguistic groups. This includes those who practice Islam and Christian farmers who descend from migrant families from other parts of the country who have settled in Mindanao since the 1900s.

The life-threatening events have taken their toll on the well-being of a large number of individuals, families and communities. Deaths, separation of families, eviction from ancestral domains, and damages in livelihoods, as well as the disruption of the other vital areas of community life have resulted in severe stress and trauma and aggravated social tension in villages with multi-cultural characteristics. In these communities where Balay have been facilitating rehabilitation work as a psychosocial development organization, the role of counsellors and the concept of counselling has opened up to new understandings.

Rehabilitation and counselling

For more than five years, Balay has been providing psychosocial support to a number of villages affected by war and internal displacement in Mindanao, particularly in the town of Pikit where four episodes of armed conflict have broken out since 1997. Prior to this, Balay counsellors honed their skills in years of rehabilitation work amongst survivors of torture

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and political prisoners and their families. As part of a network of human rights organizations, they have also been involved in advocacy to repeal repressive laws and decrees and to prevent the occurrence of social violence which has been the cause of traumatization of many people and communities in the country.

The concept of Balay's rehabilitation goes beyond the objective of "restoring an individual to a useful and constructive place in society through some form of vocational, correctional or therapeutic retraining or through relief, financial aid or other reconstructive measures" (Webster, 1986). Balay's psychosocial rehabilitation framework upholds the dignity of the person, families and communities and their environment; it is based on culture and practices of peoples in the Philippines; it is non-selective and it adheres to the principle of interdependence and interconnectedness promoting equality, mutual respect and mutual enrichment (Valerio 1999).

Balay's approach to rehabilitation is holistic and integrated because it encompasses the various needs of the individual and its social context (Ty, 1991). It is focused on the totality of the individuals as members of their respective family and the whole society, empowering them to regain their place within the community, reinforcing their strengths so they may eventually take on a pro-active role in the improvement of the conditions of their family, community and the society as a whole (Balay, 1999). Thus, Balay's concept of rehabilitation seeks not only to address the person or the community's physical and 'psychological' difficulties. Furthermore, it adheres to rehabilitation that considers other aspects such as collective and social life (Ty, 1991).

Victims and survivors of conflict and violence are not specific person but 'systems' in themselves. A person as a system is a whole being who communicates and interacts with his/her environment. A person establishes rules, boundaries, bonds and rituals within him/herself or with immediate relations. A person requires balance between connection and individuation. Often these victims and survivors have been portrayed to be weak, dependent and inactive, but even victims and survivors usually have great strengths. They are not worthless, defenseless and powerless peoples. Family and community are considered the victim/survivor's source of growth and strength. They usually form part of his/her group in processing activities. They are also consulted and conferred regularly related to the condition of the victim/survivor. The participation of the victim's/survivor's social units are deemed necessary since they form part of the reasons why he/she developed his/her original predispositions (Ty, 1991).

Providing psychosocial support

Working in communities with multi-cultural characteristics, Balay's psychosocial response process stresses the importance of the context of local social practices and culture (Valerio, 1999). The idea of counselling in the context of communities applies the concept of *pakikipag-kapwa* (literally, fellowship). This perspective is essential in a collectivist culture like that of the Philippines wherein the value of human dignity and well-being is believed to exist in a social interaction and spiritual connectedness (Sycip, Asis and Luna, 2002). According to Enriquez (1978), the root term *kapwa* when translated into English means 'others'. But *kapwa* is not the same as the notion of 'others', where the self (*sarili)* is seen as distinct and separated from the rest or others which is known as *iba* in the Filipino language. Instead, the term *kapwa* connects the *sarili* and the *iba* (self and others)

to achieve a consciousness with a collective reference. *Kapwa* further recognizes that the concepts of *kalusugan* (health) and *mabuting kalagayan* (well-being) have a dialectic relation to societal events and situations which is why counselling or psychosocial intervention should be integrative and encompass internal as well as external dimensions (Enriquez, 1985).

Below are two case studies on counselling in multi-ethnic communities devastated by armed conflict. The first deals with counselling for individuals (persons-in-context), and how their healing is achieved through individual processing and through social interaction that establishes the dialectical relationships between mental health and social well-being. The second illustrates a notion of counselling at the community level where the activities address psychological and social issues amongst groups and peoples caught in a violent situation.

Case Study I: The healing of an individual in the context of social recovery
Ginnie is the eldest and the only girl amongst three siblings. She was only 12 years old and a sixth grade pupil when her young life was visited by a tragedy. Sometime in November 2001 her community, which is co-inhabited by native Maguindanao and Ilocano settlers in Pikit, North Cotabato, was alerted by sporadic bursts of gunfire. It turned out that some Maguindanao-speaking armed men from another place had swooped down on their village, occupied a section of the highway and taken a passenger bus hostage.

The villagers scampered to safety. Ginnie and her family sought refuge behind a big tree. Unfortunately, the armed men also went there. When the soldiers arrived, the armed men fought back. They took some civilians as hostages and eventually killed 5 Ilocano men, including Ginnie's father. Ginnie herself was wounded in the left thigh.

The soldiers eventually drove away the armed men, but the entire community was in a state of shock. Aside from the trauma suffered by some individuals, the village was divided along ethnic lines. The previously good relations between the Ilocanos and the Maguindanaos in the community were shattered as mutual suspicion and distrust drove a wedge between the two groups.

When the security situation allowed it, Balay workers did an assessment of the whole situation at community and individual/family level. Ginnie and her family were considered to be among those who were severely traumatized by the incident. Counselling and related psychological processing activities were offered to her and others who suffered. At some point, they were also grouped for joint therapy. The pain and anguish of individual survivors also reflected the pain being suffered by the community which lives in a state of tension and anxiety. Hence, the psychosocial intervention was offered not only to the individual survivors, but to the distressed community as a whole.

The data gathering activity was designed to be a processing and debriefing event in which members of the victims' direct family and various sectors from the community participated. While there was focus on the needs and particularities of those who lost a loved one, they were regarded as part and parcel of the community healing that Balay facilitated and supported.

Some of the activities were counselling at individual and group level. Family encounters were organized to gather family members together to resolve issues among themselves and plan for the future. Group processes were also held seeking community dialogue involving Maguindanao and Ilocano families and some key community and religious leaders who survived the tragedy. Economic and livelihood support was also provided to encourage the survivors to work together again and to resume their productive lives.

The specific concerns of the school Ginnie attended were addressed through visits and dialogues with the teachers and other significant people in the school. The church, where Ginnie's family was very active, was also engaged by Balay to forge a common process to facilitate Ginnie's recovery and healing.

Ginnie and other children, both Ilocanos and Maguindanaos, were invited to participate in summer camps where they were given venues to ventilate their emotions and issues for and against each other in the spirit of openness and understanding. The overall aim of the processes and activities was not only directed towards Ginnie's suffering and traumatic experience; the changes in the lives of the people in the whole community after the incident, including Ginnie's, were also addressed in the context of the shared stories and experiences and collective healing, using more than the values and principles that could be derived from counselling sessions.

Case Study II: Community counselling in Saranay-Gantung

In the village of Saranay-Gantung, the Maguindanaos, the original inhabitants, have learned to live together with the Bisaya and the Ilocanos who migrated from the central and northern parts of the Philippines. There are 158 families living in the village. These families have established kinships with each other through inter-marriage and have developed a multi-cultural and inter-faith community of Muslims and Christians. But the social well-being of the community has been disrupted by repeated violent incidents. The most recent incident took place in 2003 where civilians died, farm animals were lost and houses and crops were destroyed following the assault of an armed group.

Due to the repetitive attacks, fear and anxiety gripped the villagers. Many of them suffered sleeplessness and a loss of appetite. Those whose loved ones were killed went into deep grieving and developed intense hatred for those who attacked their settlement. Amidst this critical state, feelings of mutual distrust and suppressed loathing grew between the multi-cultural members of the population. They secretly blamed each other for allowing the tragedy to happen. The children lost interest in going to school while those who used to play together suddenly avoided each other. Overtaken by mixed feelings of anxiety, inactivity and boredom, some youngsters were lured into gambling. The use of illegal drugs was also reported. The Maguindanao and the Ilocano farmers who used to work together in the fields discontinued to do so. There were some families whose members had to leave home to keep away from interpersonal strife arising from the repressed atmosphere of hostility in the community. Some family members were separated because of the need to find work outside the community. The people became poorer and hunger set in. Outbreaks of various illnesses were noted.

Community assessment
The violence had become a blow to the community's social network which damaged the accepted social order and thus shook the very source of the people's sense of security. These social protective factors are based on kinship, culture and faith which define the community member's identities as individuals and as a people in the context of socio-cultural interaction and economic interdependence (Torres, 1985).

Balay workers used the Rapid Assessment of Mental Health for Refugees and Displaced Population (RAMH) of the World Health Organization (2001) to systematically assess and understand the conditions of the people in the community including the cultural, political, social and economic dimensions of their experience. It complemented the trauma assessment checklist adopted by Balay to find out whether there are individuals experiencing post traumatic stress disorder (PTSD). However, the diagnostic tool met some limitations in identifying the effects of violence at population level.

In using the RAMH, Balay modified some of the questions and the language in order to suit the local context including the culture of the community. Adopting the community-based approach, Balay psychosocial workers went and stayed in the village to reach out to the affected population. Apart from trying to identify the negative effects of experiences of violence, Balay also exerted effort to surface the capacities that were still intact in the affected persons as well as the functional and potential resources necessary for recovery that could be found within the community.

Balay has used the help of local volunteers in gathering and synthesizing data from the community. A variety of methods to collect information were applied such as *pagtatanong-tanong* (asking questions in a conversational, personal manner), *pakikipag-kwentuhan* reciprocal story-telling), *talakayan* (discussion) and p*akiki-salamuha* (participation/ immersion in community life). All these methods were geared at consolidating the facts and coming up with a full assessment of the situation. These methods were also intended to foster a cooperative relationship through introducing the psychosocial rehabilitation workers as facilitators and partners who were reaching out to the community members and not as external experts who were outsiders. Owing to the natural and spontaneous quality of the methods used, people in the community were less intimated and suspicious. In the process of sharing information, they were also given the opportunity to examine their situation so that they became participants in the assessment of the facts that were relevant and important to them. The results of the community assessment were shared and discussed with the villagers through a community assembly.

Community dialogue as counselling
Psychosocial workers and counsellors organized a series of *ginabayang talakayan* (guided discussion) and inter-cultural dialogues. Approximately 40-60 persons participated in each activity. Community volunteers selected the participants based on whom they believed were respected by the people and who could share meaningful insights during the sessions. Dialogues among the young people and the women were organized separately.

In these activities, a group of volunteers offered to cook meals for the participants. Others provided security through ensuring that the sessions would not be disrupted. A prayer was offered before the start of the dialogue. All those who wished to speak were given the

chance. Sometimes the discussions could be provocative and full of pain and ill feelings. The elders and other significant community members were assisted by Balay psychosocial workers in promptly clarifying misunderstandings. They also bridged disagreements and comforted ruffled feelings.

Not all sessions went smoothly. Neither were all issues instantly settled in one meeting. The next sessions were considered as important as the first. The meetings often lasted the whole morning. In some cases the interactive sessions took a whole day to finish. The prayer times of the Muslims were observed, as well as the time of farmers to attend to their crops. The gatherings were scheduled to ensure that they would not get in the way of production tasks and rituals of participants. Everybody was invited to participate in meals. These occasions enabled the participants to be relaxed and to interact more freely with each other. This contributed to the restoration of their rapport with each other.

Mutual story sessions were also held where the stakeholders looked back at the history of their community using the historical timeline method. They talked not only about the negative events which they had experienced collectively; they also relived stories about the strong bond and cooperation that existed between the indigenous Maguindanao people and the migrant settlers before the armed conflict disrupted their village. Together with Balay workers, they visited the places where the violence had taken place. They determined the extent of the damage done to their community resources and illustrated it through the use of hazard and resource maps.

Healing and actions
In these processes, the Balay psychosocial workers had worked with village officials, religious leaders, respected elders and women. The series of activities led to the identification of the following goals: reduction of the risk of violence in the community, easing of tension and improving social relationships among the population, better understanding between the Ilocanos and the Maguindanaos and resumption of production activities in the community.

In order to attain this the stakeholders had (1) asked the parties in conflict to spare their village from fighting; (2) sought the support from the government and NGOs to provide support for planting materials, fertilizers and tractors; (3) raised money to replace the work animals of some families that were lost during the fighting; and (4) revived the practice of mutual support to farming activities.

The villagers decided to hold the *kanduli* ritual to celebrate life and to mark their resolve to get past their tragic experience. The people and their supporters pooled their resources to organize the event. Some volunteered to prepare the food. The elders and the religious leaders led the program. Village officials and NGOs asked those who had left the village to return. They also invited government authorities, peace intermediaries and other sympathizers to join the gathering. The occasion signaled the restoration of kinship between the peoples of different religion and culture in the community. The villagers agreed to a peace covenant. An interfaith prayer was offered and food was served as a peace offering. The council of elders talked to both the rebels and the soldiers. The leaders of the rebels apologized to the villagers for the violence that happened. The soldiers committed themselves to not start armed fighting in Saranay-Gantung.

The villagers obtained rice and corn seeds, bags of fertilizers and some heads of livestock and poultry to breed from the local government and NGOs. The farmers were able to grow their crops once more. Many joined the training and seminars organized by Balay which concerned issues such as peer counselling, livelihood development, human rights and culture of peace. Some women-leaders joined a delegation of displaced peoples to Manila to ask the president and the military officials not to use war anymore to settle political problems in Mindanao. Other stakeholders joined the *Bantay Ceasefire* – a grassroots-led network that monitors the observance of truce between the government and the rebels. The young people formed an interfaith and multi-cultural organization composed of the indigenous Maguindanao and migrant settlers. Social activities slowly returned. There was less fear to walk at night. The children began coming out to play with each other again. When harvest came some farmers decided to offer their excess yield to the people in the adjacent community to replicate goodwill and to inspire others to work towards healing, peace and development.

Conclusion: community counselling and peace building

The case studies have tried to show how Balay combines therapeutic techniques with local social practices and indigenous rituals in a community to establish an interaction in a mutual helping process at the individual, family, group and community level. They have presented an understanding of counselling thought and practice that is relevant and attuned to the needs of the people (Salazar, 1985). Moreover, the work of Balay underscores that while concepts, values and practices derived from other countries may be good, they may not be always effective in the given context. Hence, psychological and social responses should always consider the socio-cultural dynamics. Nevertheless, the integration of some Western counselling thoughts and practice into the local praxis may be viewed as an enhancement of Filipino psychology as a scientific discipline.

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Creating meaning during occupation: Social relationships in the counselling of Palestinian torture survivors

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Israeli oppression and abuse of the Palestinian people has lead to a complexity of traumas and damage in humans and in social relations. A three dimensional community health approach focusing on family, networks and society seeks to rehabilitate individuals and to restore social capital. A profound understanding of the political situation and the motivations behind political activities is paramount for successful rehabilitation and requires both professional and human involvement from the therapists.

Introduction

Dispossession, forced migration, occupation and economic siege. These are tools used by the Israeli government since 1948 to oppress the Palestinian people. Fifty seven years of systematic violation of virtually every internationally recognised human right. Since the beginning of the Israeli occupation of West Bank and Gaza Strip in 1967 even more overt and destructive abuses have been used. This includes massive imprisonment with more than 650,000 Palestinians detained during the last 38 years. This number is about 20% of the Palestinian population in this area.

Torture is used systematically by the Israeli authorities in the conflict. Humiliation, sexual torture, systematic beatings and food and sleep deprivation are only some of many torture methods applied. Torture is used to obtain information from the victims and to weaken the core of the prisoner's personality. Furthermore, torture aims at destroying the victim's personal network of support, destroying the social structure of the Palestinian society as a whole as well as discouraging any thought or speech against the dominant power.

Additionally, the Israeli army has systematically shelled and destroyed Palestinian residential areas during the current Intifadah (Al Aqsa Intifadah). As homes have been bombarded and made uninhabitable, many Palestinian families are living in tents.

On top of this, the economic crisis leading to unemployment and poverty and a political development marked by the failure of the peace process represents severe ongoing stressors for the Palestinian population.

Hence, a significant part of the population has been directly exposed to torture or other human rights abuses, and the society is heavily marked by economical constraints as well as oppression and human rights violations carried out by the Israeli occupying forces.

Families, networks and communities

In order to improve this situation and to enable victims of violence to cope with their traumatic experiences, individual treatment and social support is being provided by the Gaza Community Mental Health Programme (GCMHP).

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The programme runs three clinics that serve the population of the Gaza Strip. Therapy is provided to patients through multi-disciplinary teams predominantly consisting of health professionals but also of social workers. The psychotherapist or counsellor as part of the multidisciplinary context involved in helping the survivor is fundamental to our work.

Our work is based on a community mental health approach, which considers three levels of Palestinian social life: family, network, and community. We understand these levels as dimensions of systematic interaction in which individuals participate and through which they generate meaning and purpose in their lives.

Family

In the Palestinian family, gender and age play a big role in determining responsibilities. The father is usually the head of the family and the provider for its needs while the mother plays a key role in raising children and taking care of the home. In the past, most major family decisions were made by the father alone, but this has changed in recent years, and today some decisions are made jointly by both parents.

Sons and daughters are taught to follow the inherited traditions and are given responsibilities that correspond to their age and gender. Sons are usually taught to be protectors of their sisters and to help the father with his duties inside and outside the house, while daughters are taught to be the source of love and emotional support in the family and to help their mother with household chores.

Palestinians teach their children cultural values and customs from an early age. Expanding in range as the children grow older, there are certain duties, responsibilities and expectations of social behaviour for every age. Thus, an individual who grows up in a family inherits and internalises a range of meanings and habitual patterns or behaviour through which he or she relates to others to give meaning to his or her experiences of the world.

All this suggests that it is not only the particular characteristics of the individual survivors which predict psychological adjustment after traumatic events; it is also plausible that the family atmosphere shapes the ways in which the survivors can use their competences.

Consequently, a supportive family is the best recovery environment for a trauma survivor. Indeed, Garbarino (1992) observed that children cope better with stress and traumatic events if they retain strong positive attachment to their families and if parents continue to protect their sense of stability.

On this basis, the therapeutic team works with Palestinian torture victims and their families by making home visits to provide family counselling, psychosocial education and social support to help not only the victims themselves, but also to help their families cope with the victim's traumatic experiences.

Network

Individuals who have grown beyond the stage of infancy relate to many other individuals outside their families: friends, neighbours and peers. These relationships have a sort of regularity and continuity over time and can be labelled networks. The individual develops

further patterns of interaction and communication through these networks, thereby elaborating his or her comprehension of the world and everyday life (system of meaning), whose basis is initially formed in the family system

Palestinian networks help and support each individual in the society and enhance the person's sense of well-being by providing social and economic resources through their own collective efforts, social integration and interaction. In this way, networks enable people to deal with ongoing problems and changes. These factors and their positive impact help to strengthen those that have become weak. Both the informal sector (family, friends and neighbours) and the formal or professional sector (doctors, nurses, social workers and the rest of the health care professions) play significant roles in this process.

The GCMHP's team also works with networks through local advocacy and networking. This involves interaction with a large number of local civil society institutions. The team issues statements and appeals according to events and works at community level to prevent abuse and to promote respect of human rights, especially concerning issues relating to torture and its psychosocial effects and goals.

The importance of support networks is generally recognized within the health and mental health sciences and understood as an essential and significant determinant in maintaining health, recovery from illness, preventing the ill effect of torture and recovery from trauma.

Although Palestinian culture, traditions and Islam strongly stress the importance of friends and neighbours taking care of each other, we can see how the Israeli organised violence, in all the aspects described above, is aimed at destroying the interaction between people and controlling the ways of socialising and relating to each other. This includes the siege and separation of Palestinian villages and cities to prevent the social interaction amongst people. Thereby, the Israeli assaults on the Palestinian social support structures have left a weakened social support system.

Community
Both the family and the networks exist within the context of a larger group of people with a shared language, a shared comprehension of the world and everyday life (their system of meaning), shared pattern of interactions and communication and shared symbols, values and concepts of individuality.

The culture of the community gives meaning to the survivor's experience in the language and symbols of his or her community. Thus, it is of utmost importance to recognise the rich sources of meaning and symbolism available to the survivor from his or her own culture.

The destruction of the community, within which the family and network have existed and from which they have derived their most fundamental values and systems of meaning, is one of the most demoralising experiences for torture survivors.

At the community level, many activities have been carried out by the team, such as the production of a bi-monthly journal, which has a wide local distribution, on issues of human rights, imprisonment, torture and rehabilitation. Public education and media activities target

the community at large and provide training courses for police/prison personnel on human rights related issues and mental health.

Aspects of counselling and psychotherapy in Palestinian culture

In accordance with the three dimensions, family, network and community, CGMHP adopts a community mental health approach that is sensitive to the needs of Palestinian society and its culture. It is necessary to take the social nature of human existence into account and to recognise that a person's sense of self is rooted in his or her relationships with others. Our focus therefore shifts from the ´individual' person to the 'individual in relation to others', which leads us to focus the counselling on these social relations. Following this, we understand torture and organised violence as an assault, not on an individual alone, but on the family and the community to which that individual belongs.

The family plays an important role in the therapeutic process. Home visits are made with the aim of involving the family of torture survivors in the treatment plan, thereby ensuring that survivors have a supportive environment to facilitate treatment. The implementation of community educational campaigns which seek to reduce the stigma associated with mental illness and raising awareness of mental health disorders in the community are also used.

Much caution is taken in building the relationship between the therapist and the survivor. First of all, it is important to respond to the role that society gives the therapist. In the Palestinian society, the therapist is looked upon as an authority figure in the same way as parents, teachers or leaders in society who are considered powerful and responsible. Moreover, the therapist is seen as a representative of the community and not as a representative of the individual. These characteristics are important to respond to by the therapist to ensure a successful therapy or counselling process.

Treatment of Palestinian ex-political prisoners is often difficult due to the problems of constructing a trust-based relationship to the therapist. The ex-political prisoners consider themselves heroes who have fought for freedom and nationhood and feel that they should not have psychological problems. Therefore, they are hesitant to accept the need for treatment. They have always told stories of their heroic experience – the only stories that people want to hear - and identify themselves with symbols of power. They posses a strong self-image that cannot be compromised by acknowledging weakness or personal problems. Hence, in order for the therapist to build trust between him or herself and the client, the therapist must pursue an equal relationship where the experience and active participation of the survivor is given priority.

Recognition, respect and understanding of religion, the socio-political context and the personal values of survivors is also important in the therapy. The therapist has to understand the culture and the political attitude of the torture survivor and the meaning of individual differences on political and ideological attitudes. He or she should also know how to recognise these differences and shape the counselling and therapy to fit the client's world.

To create a safe environment, the therapist has to listen and to share the experience of the client. It is important for the therapist to be aware of his or her own behaviour, especially

not to remind the victims of the interrogators' behaviour. Otherwise, the survivor will feel vulnerable which will prevent him or her in expressing him or herself and to talk about his or her suffering. At the same time, the therapist should be aware that the survivors often use denial as a defence mechanism to establish a state of psychological balance. Building trust between therapist and survivor is therefore key to the successful treatment. Providing new relationships in which trust and empathy can be re-established provides a basis for the generation of new meanings with which the torture survivors can make sense of their experience.

In paying attention to the survivor's socio-political status and subjective experience, it is necessary to take account of the social nature of human existence and to recognise that a person's sense of self is rooted in his or her relationships with others. This means that therapists should understand the sub-cultures of the society and have sufficient knowledge of the different Palestinian political organizations to establish a good therapeutic relationship with the victims and their families in order to facilitate the therapy process. It is fundamental for a successful process that both the survivor and the therapist understand the political-social-historical context and know that the survivor was subjected to torture scientifically designed to destroy the core of prisoners' personality and the social structure of Palestinian society.

All the above mentioned elements enhance and facilitate the therapeutic relationship with the torture survivors.

Conclusion

In this article, guidelines to understanding the individual within the contexts of family, social network and community have been presented. It is through contextual relationships that individuals establish and maintain a sense of identity and a sense of meaning and purpose in their lives.

Torture and organised violence radically transform and sometimes destroy these contexts of family, network and community including the patterns of relationships within them. The transformation or loss of these patterns of relationships drastically undermines the individual's sense of purpose and meaning in life. It is, therefore, extremely difficult to retain a sense of continuity and to reassert a sense of identity, purpose and meaning. The individual not only suffers mentally and physically but is also faced with new economic and socio-cultural problems.

In our work with torture survivors, we focus not only on the torture and its impact on these individuals, but also consider how their relationships have been changed and how they understand themselves now as a member of the community. Our therapeutic task is to provide a context in which previous systems of meaning can be recovered and new ones developed.

Palestinian patients seeking treatment for their psychological problems have unique characteristics related to socio-political, cultural, and other factors that affect the therapeutic process. These patients present challenges to their therapists due to the contrasting cultural understanding and conceptualisation of mental illness and therapeutic

process. Therapists need to fully appreciate the relationship between culture and psychotherapy, especially when providing counselling to ex-political prisoners.

We are further aware, not only of the value of scientific theories, generalised categories, and conceptual frameworks, but also of their limitations. We see our role not so much as directors and organisers of a process, but as participants. This calls for us to engage in the process not only at a professional level, but also at a human level; to be prepared to subordinate our scientific theories and professionalism in a struggle for human rights and human values.

The process of arrest, torture and release involves trauma at many levels. This trauma can be understood, not only as an assault on the individual person, but also as an assault on the links and connections between people and patterns of relationships through which people define themselves and give meaning to their lives. As Palestinians, we share a trauma which has affected us all. We all need help and can give help to others in return.

However, without stable political and geographical boundaries and without recognizing the right of others to re-build their countries, the suffering will increase. That is why those who inhabit communities that are currently stable and democratic must support those of us who have chosen to practice our therapeutic task, at great personal risk, in countries under occupation. As Palestinians we share a trauma which has affected us all.

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Working with sexually abused clients in Zimbabwe

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In Zimbabwe, rape must be understood within a political context. So must the treatment of rape victims, where human rights activism should be combined with therapy, the provision of material needs and traditional beliefs appreciated.

Introduction

Probing the dark recesses of the male psyche is a preferred option when an explanation is sought as to why rape happens. We should not forget, however, that all rape takes place in a societal context. This context may be called *cultural* ("if a woman dresses like *this*, she must be aware that men would see it as an invitation"); it may be called *religious* (e.g., when virgins in Iranian prisons were raped before being killed to make sure they would not directly enter paradise as the Qur'an promises virgins); and it may be called *political* (e.g., when soldiers rape the women of their adversary as part of warfare).

In the case of Zimbabwe, the political context is such that rape is actively brought about or condoned by the Government by creating conditions which:

- make it possible for rapists to frame their common crime post hoc as a political act, and thus avoid legal prosecution, while at the same time making it extremely dangerous to provide help for the victims as therapists may be accused of meddling in politics
- undermine the judicial system to an extent where, even if the letter of the law allows prosecution of rapists, the victim's chances to find justice are slim due to unfilled posts, incompetent officials, chaotic record keeping and bribery
- seriously reduce the chances of victims to be attended by competent medical professionals as in many places there is no longer any doctor, let alone one with specific training regarding sexual abuse.[2]

These conditions are not merely of academic interest, but describe the reality which victims of sexual abuse and their therapists as well as doctors and lawyers have to face. That is, if the victim has even gained access to professional assistance. Working with these clients thus becomes a complex issue, where it becomes difficult to separate 'therapy' from *advocacy, social work and human rights activism*, regardless of who the abuser is. Fear of men, fear of the unknown, feelings of sadness or depression, the feeling of being tainted or unclean or of having lost one's dignity are feelings commonly associated with rape. These can too easily be mistaken to represent 'the' rape experience and in our setting they are just some of the many problems that our clients have to come to terms with in their life after the rape.

[1] The author to this article has wished to be anonymous. The person is known to the editors.

[2] It may be worth explicitly mentioning that Zimbabweans enjoyed high standards of judicial and medical professional services until quite recently. As a result of their loss of majority support, the Government made it their number one priority to do what ever it took to hold on to power. The ensuing economic melt-down triggered the mass emigration of competent professionals, and they were replaced by junior staff or even by political appointees. As a consequence, performance standards have dropped dramatically.

We work with clients who have been sexually abused a long time ago in the Gukurahundi era[3], or more recently in youth militia training camps. We also work with clients who have been abused by relatives, caregivers or other people known to the client, or in rare cases by strangers. We have found that clients' needs, such as the need for safety, the need to talk to someone who understands and is supportive and the need for essential services (medical, social, and legal), are quite similar in all these cases. Although it is true that work is initially easier in non-political cases because all case-related activities may take place in the open, this distinction may fade over time. As we as therapists make a client's case our own and challenge collapsing services and confront bribery and a culture of impunity, an initially intra-familial case of rape may turn 'political' at any time. As a result, issues of our competence as therapists get mixed up with issues of human rights activism: How far should we, or indeed dare we go in confronting an abusive system that re-traumatises our clients? How do we find an ethically acceptable balance between defending one client (e.g., in court), and preserving our chance to continue to work with other clients, in a very uncertain political environment?

Many other factors need to be considered: The coping strategies of clients differ depending on their life circumstances, such as a supportive environment and access to services. Cultural beliefs and values play a big role, and in all our interactions, we must take cultural norms into account, rather than just applying skills and techniques learnt in Western-type counselling training. For tortured clients it may take years before they access any service or receive any help, and when they do get help it is usually not adequate. We have found that clients appreciate to have somebody to talk to (even if Zimbabweans traditionally feel that personal matters should be discussed within the family, not with professionals), but that healing itself may take a long time. Specifically in cases of current torture, the environment (feeling of security, possibility to meet as often as wanted and needed) is usually far from ideal. In most cases, clients have other needs in addition to finding an empathic listener. Indeed, in the course of working with a client, it may turn out that the rape is not the top item on their list of problems.

One may call the approach which we have found most suited to meet our clients' needs *systemic*, in that we pay close attention to all the systems of which they are a part. However, we do not confine ourselves to facilitating a better *understanding* of their predicament as a basis for their subsequent actions. We go beyond exploring the intra-psychic and/or relational aspects of their real life problems. We have already alluded to the breakdown of governmental support systems, but in the wake of the HIV epidemic and economic melt-down, this often applies to family systems as well. As a response, we get involved in solving our clients' practical problems if they, in our own assessment, are not able to manage them on their own.[4] We are aware that in doing so, we go beyond what is considered proper psycho-therapeutic treatment.

[3] A period of time in the 1980s where the government waged war against the AmaNdebele minority and killed at least 20,000 people.

[4] For example, if clients need specialist medical care, it is very likely that a referral to a government facility will not lead to them seeing a doctor, or it will lead them to see a doctor who is less competent than the doctors on our staff. So we use our contacts in the system, make appointments with specialists whom we know personally, and take clients beyond the administrative barrier of receptionists and nurses erected around medical specialists. Also, we sometimes accommodate those who come from afar until the day of their appointment.

We shall try to highlight some of the above issues in the following case examples in which the names of clients have been changed for reasons of security and confidentiality.

Case I

In 1985, Phathi was gang-raped by nine soldiers who had come to her village looking for her husband whom they accused of being a dissident. She got medical help from a mission hospital some weeks after the event when it was safe enough for her to travel again.

Her life became a misery: her husband stopped having sexual relations with her and sometimes even blamed her for the rape. She would sit for hours all by herself and nobody would pay any attention to her. The husband no longer consulted her on family matters, friends did not visit and she felt that if she were to become ill and die, or if she took poison, nobody would care. Her life had changed so much that she did not see the point of living any more. In our sessions, Phathi complained most about her husband's lack of support and that he thought of her as 'messed up', no longer being good enough for sexual relations. He left home for long periods without notice. Phathi was afraid that her marriage was about to break up and suspected that her husband had another sexual partner. This other woman, she thought, might have performed some traditional ritual (*isicitho*, meaning 'disintegration') and this would destroy the family. Phathi had already seen physical evidence of being bewitched: a civet cat had passed by her home which must have been sent by that other woman. The civet cat is a smelly animal and Phathi took its presence as proof that bewitchment had made her smelly as a civet cat and therefore sexually unattractive to her husband.

Phathi's parents were no longer available to assist; her mother had died and the father had disappeared during Gukurahundi. She was left with two brothers who could not help much, because Phathi as a married woman was under her husband's authority. The husband had paid *lobola*, dowry, and now that Phathi had been abused, she believed that, according to tradition, her husband should take another wife because she felt that she was no longer worth the bride price. Her family of origin was not of much help – there was no unmarried sister or niece who could be offered as a second wife. At the same time, the husband could not ask for financial compensation from the soldiers who had abused his wife to raise the money with which to get a second wife.

When asked, Phathi's husband agreed to come to a session with her. He blamed his wife for having changed, being mostly in a depressed mood and isolating herself "as though she was in mourning". He stated that he found staying at home very depressing. He would not be drawn into discussing the sexual relationship with his wife or with another woman.

I then brought in a male colleague from our team to explore further with the husband how he saw and felt about the situation. However, working with the couple became difficult in the run-up to the general elections, where staff at the local clinic (the place where our sessions took place) came under scrutiny by security agents because of the collaboration with us. It was not possible separate our identities as therapists and as human rights activists. As the political environment worsened, we lost track of the couple and at present we have no information about Phathi's status.

It is not satisfactory to become dissociated from a case in such a way, and I felt sad about letting Phathi down. At the same time, I experienced a sense of relief. With the approval of

my colleagues, I did not have to expose myself to danger any more, and I could avoid addressing some very tricky questions: how, as a human rights supporter, should I deal with the issue that according to tradition, Phathi's family of origin is under pressure to compensate the husband, who has paid *lobola*, for a wife that has become 'useless'? Phathi is clearly a traditional woman, so taking a firm stand *against* a traditional view that appears inhumane and disrespectful of women would not be an option for me, as it is not an option for her. This case also demonstrates, like the ones to follow, how current politics interfere with the idea of a neutral therapeutic space.

Case II

Mtha was admitted to a hospital after a suicide attempt because her uncle, whom she had reported to the police for raping her over a period of eight years, had been released on bail after initial interrogation. Mtha's parents had died long ago, and she had stayed with a very old grandmother who did not have the resources to look after her. So the uncle had taken Mtha in on the pretext that he would assist with her schooling, and had subsequently abused her.

When I first met her, she was in an almost catatonic stupor and I fought with the hospital staff for three days to secure her the bare minimum of services: a psychiatric and forensic assessment and adequate interventions. Twice I had to avert imminent discharge by junior doctors who did not even know her history, and she had still not been given *any* service. In the end I got Mtha admitted to a psychiatric facility, but not forensically examined. The gynaecological consultant refused to consider her mental state and simply claimed that an examination could not be done as she did "not co-operate".

When I visited Mtha a few days later at the psychiatric hospital, she had not yet been seen by a doctor there and had not received medication since her admission. The nurses' explanation was that admission had taken place during the Easter Holiday. A psychiatrist then examined her, diagnosed a reactive depression and put her on medication (anti-depressants and anti-psychotics). This was his only line of intervention.

Mtha had her first sessions with me whilst she was still in hospital. She continued to be suicidal but was not, in my opinion, psychotic. Her worries about attempts at her life through long-distance food poisoning (by the uncle's wife who she believed to be a witch), labelled as psychotic by the psychiatrist, are compatible with generally accepted local traditional beliefs.

After discharge from the psychiatric hospital (which I recommended because Mtha didn't feel safe from witchcraft in a place where many people came and went), I put her up in a small shelter for children. I saw her regularly there, several times a week, and we had sessions that covered many diverse issues: her suicide attempt, the history of her rape, the possibility of a future back at her granny's, nightmares, the witchcraft of her aunt and ways of protecting herself against it. At one point, Mtha had psychogenic seizures, a problem which needed our attention. Furthermore, I had to argue with the NGO that runs the home she was staying in, as they wanted to send her away because she was *too much trouble*, even though the home was meant for children in trouble.

On the legal side, the investigating male police officer tried "to get the case dropped"[5] by telling the prosecutor that Mtha was unable to give an account of her abuse. Through the prosecutor, I had to request for a female investigating constable who *was* able to elicit a coherent story. But for reasons unknown to me, the case was handed back to the previous officer who did not forward Mtha's file to the courts. Next I found out that the wife of the defendant had requested that the case be dropped as her husband had been supporting Mtha and other relatives with food. My physical presence at the police station was needed to eventually get the file to court.

I have worked with Mtha for almost a year and she has made a significant recovery and is now able to attend regular school. I have visited the grandmother's home in the rural areas and found it safe for Mtha to stay there. The main constraint there is a lack of material resources to support the family. Mtha is still on psycho-active drugs, so she needs to come to town for reviews, and we must push for a hearing in her court case, which also necessitates her presence in town. The lack of attention to her problems in hospital, the reluctance of the police to take her case to court and the wish at her shelter to get rid of her when she most desperately signalled her need for help, all point in one direction: Mtha needed massive support in all these settings. On her own, she was too weak to make her voice heard.

As for my psychotherapeutic approach, many hours were spent trying to understand how Mtha's life had unfolded the way it did, and how she would make sure she would not be abused again. This also included assertiveness training with role plays where a male colleague proposed sex to Mtha to let her enact and experience different ways of controlling the situation. Specifically, I would like to make a comment on the witchcraft issue. The one thing that helped Mtha when she had nightmares was prayer. She is a Seventh Day Adventist, so I organised for her to attend their Saturday services, where she could share her plight and ask others to pray for her. In her presence, I had a blanket blessed by a priest as a witchcraft repellent in which she could wrap herself at night. I had found out that she did not have enough blankets to keep herself warm and figured that even as physical comfort, another blanket might give her a better sleep and less bad dreams, thus enforcing her belief in the blanket's protective properties.

Case III

12-year-old Zodwa was sexually abused in a militia camp in 2003. She was picked up by militia youths because she happened to be selling vegetables for her employer at a street corner next to the camp. Zodwa never understood why she was in the camp and no one would explain it to her. All the youths were much older than her, but her young age did not protect her and she became a sex slave just like the other girls. When the camp closed, Zodwa had nowhere to go as her employer seemed to have fled from the area.

When I first saw her, she appeared confused and did not seem to understand how her life could have turned that way. She was weepy and did not know what to do; she looked sad and lost, with a blank face, and had to be prompted continually to carry on with her story. Our venue was very inadequate as Zodwa could only be seen in a bushy area near her camp,

[5] This is the wording of the prosecutor.

and only three sessions were possible: she, as others, was under constant surveillance of the camp leadership.

The most important thing to me was to get Zodwa to safety rather than continuing to work with her in the extremely unsafe environment. I found out that she could go to her grandmother in a far off rural area, so we hired somebody to assist her to reach home by bus. I later received a letter from the grandmother that she was thankful that the spirits had guided the child safely home. She wrote that Zodwa still needed medical treatment from a nearby hospital, and that she was going to organise a traditional cleansing ceremony because the girl had witnessed a lot of evil deeds in the camp and this was not conducive to her physical and mental well being.

In this case, we unfortunately had to settle for *no* therapy, and for the provision of transport home as the best offer we could make. Worries about Zodwa's and my own security were so prominent in my mind that I did not dare to continue seeing her.

Discussion

The problem of sexual abuse is all too easily denied in Zimbabwe. Victims of rape, but also therapists, may prefer to focus on other physical injuries and overlook the sexual abuse. Spouses and relatives, although deeply affected, may choose denial as a coping strategy. Victims, relatives and the wider community may suffer from feelings of defeat: "The damage has been done; it is not reversible; we were unable to prevent it from happening." The suffering of primary and secondary victims is thus ignored. People are too scared or ashamed to talk about it. In part, as a result of this, little or no action is taken by victims and communities to redress the situation by making the perpetrators accountable for their actions.

In initially non-political cases, human rights abuses may abound in a victim's life after rape, such as the lack of action of the police and the neglect in hospital, which Mtha encountered. When a case is political to begin with, current developments may make work difficult, even in cases of historical abuse. If the abuse is current, therapy can be impossible altogether for reasons of the security of the client and therapist, as in Zodwa's case. To determine the most appropriate kind of interaction with a client and her environment in any given case is therefore not just an issue of psychotherapeutic technique; of high or low frequency, supportive or interpreting, analytically or behaviourally oriented treatment.

We need to consider what is possible, regarding the oppressive political environment, without creating additional risks for clients or other health staff (as in Phathi's case) or for clients and ourselves (as in Zodwa's case). We also need to weigh the benefit of becoming confrontational, for a given client (see our interventions for Mtha in different settings) against the risk of alienating monopoly 'service' providers, e.g., courts and the police.

Finally, traditional concepts may or may not be easy to live with. That Mtha sees her aunt as a witch could easily be seen as a metaphor (after all, the aunt let the abuse happen in her house for eight years and tried to subvert the court case). We had no problem with Mtha's view so long as she was passive and all we tried was to help her build similar metaphorical defences. But what if she had tried to fight back and had tried to poison her

aunt, or if in a village setting the aunt would have been convicted of witchcraft and ostracised? What if, in Phathi's case, there had been a sister who could have been offered as a second wife to the husband without her consent?

Conclusion

In conclusion, it seems difficult to come up with a clear-cut set of specific rules, although there are some general guidelines:

1. Material needs related to the survival of the client should not be ignored. Lack of basic necessities such as food and school fees may play a role in making abuse possible, or may keep the client dependent on the abuser (see Mtha's case). Once the abuse issue has received due attention, other (material) needs may present themselves with urgency, or even take precedence over the abuse itself.
2. Traditional beliefs need to be appreciated as an integral part of the clients' life experience. Our interaction with a client may result in tradition being rejected (imagine a gay client deciding to reveal his or her sexual orientation in spite of an averse traditional environment) or affirmed (e.g., if Phathi approved of a second wife for her husband in line with expectations in her traditional setting, thus 'saving' her marriage). We may or may not find a client's choice compatible with our own value system, including our views on human rights, and may need to plumb the depth of our capacity in order to tolerate discordant value judgements.
3. We must be ready for "human rights activism as empathic, multi-faceted practical help", as stated elsewhere in this volume.[6] In a country with a breakdown of law and order, essential health, legal and social services and with rampant corruption, we have to watch out for mismanagement of our clients and to be ready to confront officials on their behalf. Those who have been wronged may be disadvantaged and not have sufficient power to speak up for themselves. The perpetrators may feel they can continue with their crimes with impunity unless human rights activists put pressure on governmental structures to perform their duty as prescribed by written law and by ethical professional standards.
4. When the need arises, these guidelines have to be complemented with a professionally competent focus on the client's communication patterns, which may have been dysfunctional even before the rape experience, or may have become so in its wake. The human rights activist thus needs to be able to take on the role of a competent therapist.

[6] Cf. n.n.:"Do survivors of torture need 'counselling'"

IV. Perspectives

Participatory monitoring of psychosocial practice in Mindanao communities affected by conflict

Ernesto A. Anasarias and Brenda Escalante[1]

Monitoring changes in the communities affected by conflict is crucial. Apart from serving the purpose of following multi-disciplinary psychosocial interventions and identifying their results, monitoring is an important tool for enhancing the capacities of the community partners. Using a participatory approach helps identify actions that stakeholders themselves agree to take, empowers stakeholders, and serves as a tool with which they can learn from successes and failures.

Introduction

For more than five years, Balay has been providing psychosocial support in conflict-affected villages in Mindanao where fighting between the government and various rebel groups struggling for self-rule has uprooted large numbers of civilians. Wars and forcible displacement cause collective suffering, affecting not only the individuals but entire groups and communities as well. Monitoring and understanding the changes in the well-being, the transformation of the social fabric, human rights promotion and healing in these communities, which are inhabited by people of multi-cultural backgrounds, is one of the most significant activities in the psychosocial practice of Balay.

The interest in this support is matched by the importance of knowing how the different human and socio-cultural resources are affected when armed conflict, forcible displacement and other forms of organized violence strike a community. This requires, among other things, knowledge of the elements of social organizations and relationships, belief systems and practices, human capacities as well as culture and values that form the social protective factors of internally displaced peoples. How the affected population responds and copes with the impact of violence may serve to indicate the level of community resilience and whether social trauma has weighed upon the individual and collective well-being.

The importance of monitoring

Obtaining information regarding the impact of violence on the social well-being of the community and understanding the relationships of the different domains' social fabric is essential in designing a community-based psychosocial development response. This information provides Balay with an adequate basis from which a healing partnership with the community in distress may be established. The information can further be used in deciding what kind of psychosocial programs may be culturally appropriate, therapeutically sound, and empowering for the affected population.

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Carina V. Anasarias and Nadia Pulmano are gratefully appreciated for translating portions of the article into English.

To grapple with these concerns requires a careful assessment and monitoring process. As part of Balay's psychosocial response, monitoring revolves around a series of interrelated activities. Monitoring entails measuring, recording, collecting, processing, and periodically analyzing information. It aims at determining the impact of violence on the mental health and well-being of individuals, families, and communities. Monitoring is also used to assess whether or not psychosocial responses facilitate healing and rehabilitation.

At the level of the institution and programs, monitoring systems and tools are designed based on a participatory, empowering, and knowledge-generating framework. Monitoring requires skills in interpreting the community relationships and the significance of an integrative multi-disciplinary psychosocial intervention. It seeks to define which of the different intervention projects, or which combination of interventions, has been successful in achieving a particular goal. Monitoring calls for a participatory discernment process where community partners are encouraged to contribute in determining which psychosocial responses work for them and which do not. Hence, the community partners can see themselves as real stakeholders who own the results and outcomes of the psychosocial projects that they are a part of. Nevertheless, the monitoring systems and tools are definitely not built and developed overnight. The success of monitoring also depends on the capability and resources of the entire organization and its partners to fully internalize and integrate the monitoring scheme into their entire psychosocial practice. Monitoring is, after all, a shared learning experience.

Understanding the context

In designing monitoring mechanisms, Balay has to understand the context from which its psychosocial response is taking place. It starts by acknowledging that social trauma is a blow to the basic fabric of social life. Social trauma damages the bonds between people and impairs the prevailing sense of community. The rupture in social life resulting from armed conflict and multi-ethnic tension challenges the victims' fundamental assumption about the safety of the world; it assaults the positive value of the self and *pakikipagkapwa-tao* (relating to others in a meaningful way); it impairs human capacities and mental health, and violates the people's right to security and peace. This notion highlights the view that the implication of the traumatic experience on an individual may be explained in the context of a household or family, which in turn is situated in a multi-cultural setting that characterizes the conflict-affected community where Balay operates.

Balay's monitoring activities cover the institutional aspect (capacities, resources, organizational management) and the program aspects (project administration and personnel performance). At the community level, which is the level of participatory monitoring dealt with in this article, monitoring is performed with Balay's partner-stakeholders in both formal and informal ways.

Formal monitoring is usually organized around meetings, discussions, giving feedback, having assemblies, and dialogues among and between community partners. The activities would usually be structured in a way where the stakeholders would be asked to present their views on changes - negative or positive - that they have noted regarding the goals and objectives of the psychosocial program.

Informal monitoring, on the other hand, is done in a casual and non-structured way during home and community visits; in casual conversations and consultations. Psychosocial workers apply the participant-observation method in these situations which also include mutual updating and story-telling activities (*pakikipagkwentuhan at pagtatanong-tanong*).

Participants in monitoring activities can be direct Balay partners who have themselves been involved in project implementation, such as peace dialogue, peer counselling, and psycho-education sessions. These may include community elders, women volunteers, youth counsellors, peace mediators, and trainers; but can also be parents, children, traditional leaders, village officials, health workers, and others who have been reached by Balay's psychosocial activities.

Most often, Balay psychosocial workers refer to a set of psychosocial monitoring guides in facilitating discussions. Community members are not necessarily homogenous and may have diverse interests and perspectives influenced by ethnicity, class, gender, age, and social and economic status. Hence, interpretation and analysis of information is often formed between and among the community participants.

Community-based monitoring

In an armed conflict situation, large numbers of people are exposed to life-threatening events. However, in places where Balay provides psychosocial support, many of them do not seem to show significant signs of debilitating symptoms of mental disorders associated with war trauma as described in much literature. Using a monitoring tool that will determine the impact of violence on the social fabric of the community and community-based responses of the affected population is one of the important decisions made by Balay.

In 2003, Balay prepared psychosocial questionnaires based on the Rapid Appraisal of Mental Health in Displaced Communities and Refugees (RAMH) of the World Health Organization (WHO). The Balay team used the guide questions to inquire about the well-being of villagers in the aftermath of the military and rebel clashes in at least nine villages in the towns of Maguindanao and Cotabato. A different set of tools was prepared for each particular psychosocial aspect that was monitored. For instance, interview and discussion guides were designed for capacity and vulnerability analysis, resource analysis, or hazard mapping.

The monitoring and assessment activities were conducted through site visits, ocular inspections, and recordings of the narratives of resource persons. Information was gathered pertaining to risks to personal and group security, economic resources, human capacities, mental health, social organization, and community response. Group discussions were held separately for women and youth. The tools were also used as a guide during assemblies where religious leaders, elected village officials, elderly, and community volunteers participated.

The main focuses of the monitoring activities vary from each community, indicating the issues and the psychosocial interventions which the stakeholders consider most important. For instance, community-partners in one village may put emphasis on the strained relationships of people of different faiths and cultures after the armed conflict. The monitoring aspect would then focus on the effects of the community dialogues, conflict resolution activities, and culture of peace seminars to the healing of their social fabric. In

another community, the villagers may find the devastation of their economic resources the most significant reason for their distress. Hence, assessing changes in their productive capacities would be more relevant, particularly regarding whether or not the external livelihood assistance they receive has made a difference to their conditions.

In many circumstances, the strain on the social fabric due to violence is manifested in the community's productive capacities. This requires an intervention and a monitoring framework that combines different psychosocial aspects in order to assist the stakeholders in regaining control of their situation and that acts towards their mutual healing and development.

Case example: monitoring the "Seeds for Peace" project in Takepan

Armed conflict and rupture in social fabric
Relations between the people in the village Takepan were strained as a result of the armed conflict between government soldiers and Islamic rebels in 2003. The Maguindanaos who are Muslim and the Ilocano and Ilonggo farmers who are mostly Christian used to work together in the fields before the fighting took place. But tension developed between land tillers belonging to the different ethno-religious groups. Each side thought that the other had taken part in the armed hostility in their area. The fighting had destroyed their crops and they feared that violence would erupt again in their village and that any efforts made to reestablish the fields would only be wasted. Therefore, their farms had lain barren for six months. They had lost livelihood opportunities during their evacuation. This had reduced their capacity to fend for themselves. Their resources for self-help had been diminished, affecting their self-esteem in the process. Their disempowerment made them anxious and disturbed their peace of mind. As a result, they could hardly produce anything. Hunger set in, especially affecting the more vulnerable groups: the children and the elderly.

Psychosocial response
When the fighting was over, Balay participated in a psychosocial response to bridge the misunderstanding between the Maguindanaos and the Ilocanos and Ilonggos. Peace assemblies were organized so that the affected villagers could discuss their thoughts and feelings about their situation. During the dialogues, they were able to clarify that all of them were victims of the armed conflict, and that as civilians their common interest lay in rekindling their community solidarity and restoring their trust in each other. In 2004, they joined the Space for Peace – a cluster of villages with a population of 22,000 people – which successfully secured the commitment of the government and the rebels in 2004 to spare their communities in the fighting. The children joined peace camps where they were given the chance to know and appreciate the cultural diversity of their communities. The adults were invited to join seminars on culture of peace.

Seeds for Peace: gardening and healing
When the villagers expressed interest in returning to their farms, NGOs offered them planting materials and farm animals to raise. Using economic means as a psychosocial development response, Balay provided vegetable seeds to 450 households clustered in 6 areas or *sitios.* The objective of the intervention was to encourage the villagers to work together, rekindle social cohesion, and reduce tension in the community. This strategy,

named Seeds for Peace, also aimed at increasing the productive capacities of stakeholders, at enhancing inter-cultural understanding, and at promoting community well-being.

Balay psychosocial workers introduced the idea of communal gardening to the stakeholders. The farmers agreed on the project objectives and committed to abide by the arrangements that would be collectively decided upon. With Balay staff acting as facilitators and project coordinators, the stakeholders decided to group themselves into different production units composed of 20 families of different cultural backgrounds (i.e. Maguindanao Muslims and Ilocano Christians). The farmers identified different parcels of land and successfully negotiated with the respective landowners so that they could start a communal vegetable farm. Four production units shared a common 300 square meter parcel of land on which they agreed to grow *mungo* beans. The farmers worked collectively on everything from land preparation to harvesting and marketing. They assigned tasks among themselves and determined their schedules in tending the garden. The project went on for about five months.

Project monitoring
During the project period, Balay came up with two related methods to monitor the Seeds for Peace intervention. One was a monthly field visit to see first hand how the project developed in stages. There were site inspections to determine whether land had been ploughed, whether planting had been completed, and whether the farmers were tending their farms regularly. Another field visit was made during harvest time. The Balay staff applied the *pagtatanong-tanong* method, a way of asking questions and mutually sharing observations and ideas in a natural and unstructured way. Through this method, the farmers freely discussed what their problems were and offered their views on how the project affected them. House visits were also made in order to note whether there were changes in the conditions of the families and to get a general sense of whether or not the project objectives were being met.

The other monitoring method was through group assemblies where members of a production unit gathered to discuss the status of their project. In the area called the Sitio Brotherhood, for instance, Balay convened four assemblies with around 30 farmers participating in each meeting. This included the meetings for the project orientation and planning and meetings during the growing period, the harvest period, and the post-production period.

During the gatherings, Balay facilitated discussions and story telling where farmers raised their concerns and shared observations. On these occasions, many things could be talked about. The participants would not necessarily have the same opinions. The facilitator had to guide them in identifying what their common views were and on what issues they disagreed. At the end of the session, the assembly gained a sense of whether the project was achieving results or not. They also agreed on their next move before ending the meeting.

Noting indicators
Quantitative indicators were identified in terms of the number of bags (or kilos) of *mungo* beans produced and the income earnt from selling the produce. The outputs were

compared with their production targets at the start of the project to know whether the farmers had achieved their goals or not. Many households had a successful harvest and had more food to eat. They also had excess harvest to share with other families. But some units reported crop failures. These things and the reasons behind the outputs were discussed and noted during gatherings and field visits. The farmers also discussed whether or not to continue with the communal farming project in the next planting season.

Qualitative outcomes were also noted, such as the decline in ethnic tension (farmers sharing farm produce), enhanced family bonding (parents and children tended the garden together), and diminished suspiciousness and mistrust among neighbors (villagers feeling able to walk safely at night). The participants exchanged views on whether or not these indicators were connected with the productivity and vice versa.

But not all indicators were positive. In one instance, a fracture in a production cluster happened due to a disagreement on how to handle the extra harvest. Some would like to use the seeds to expand their vegetable garden, while others wanted to sell it to have more income. After some discussion they decided to sell it and divide the additional income among themselves. But as a result of the disagreement the group broke up into two clusters. One group moved to another parcel of land to start a separate vegetable project.

Lessons in monitoring practice

Throughout the monitoring activity, Balay served as enablers, facilitators, and documenters. Based on practice, Balay is at the moment only able to do a particular monitoring process for a specific psychosocial program. Priority is given to to follow the developments of the Seeds for Peace project. The monitoring of other projects will be undertaken as separate monitoring processes .

Balay's monitoring methods rely very much on the narratives of stakeholders. These narratives take form of testimonies, anecdotes, stories, and metaphors which provide significant information for identifying and analyzing the project developments. While the analysis of outcomes is expected to be attuned with the project objectives, the changes which the stakeholders consider most significant are valued and respected. And since different views may surface from different stakeholders, discussions and significant insights are built around several perspectives. Understanding reasons behind a success or failure of a certain undertaking may be influenced by different factors. Biases may becloud perceptions and interpretations. Balay considers it an imperative to assist the stakeholders in developing their analytical framework and method of information analysis. This enables them to enhance their skills in acquiring significant insights and ways of moving on as a result of the monitoring process.

The analysis of the quantitative and qualitative indicators is important, especially if one has to weigh which among the project objectives is more important to achieve. For instance, the amount of harvest may indicate the level of productivity, but the restoration of collaborative relationships between stakeholders of multi-cultural backgrounds could be a more significant indicator to the stakeholders themselves.

Community-based monitoring is a tedious process. It requires sustained fieldwork activities that may take time and resources from other programs and activities. The Balay staff performed the monitoring tasks alongside other activities in the community. For instance, a field visit to a particular area might be scheduled to take place on the same day as another meeting or training activity for a different set of partners. The decision to accomplish several activities on a single trip to a community may be cost-effective, but the quality of the monitoring analysis may also be affected. Moreover, it is definitely not easy for the psychosocial worker since he or she will be preoccupied with several tasks at the same time.

Nevertheless, Balay finds monitoring an essential undertaking for growth and development of its psychosocial praxis. Balay finds strength in opening up the design of the process to include those most directly affected and in agreeing to carry out an analysis of the information together with the participants. The Balay programs are built on the principles of openness and mutual trust – a value which stakeholders who have experienced social trauma hold very dear.

Conclusion: monitoring as an empowering activity

While Balay is developing an understanding of a comprehensive monitoring framework, it is clear that it is a huge task to practice an integrative process in tracking progress in different aspects of Balay's psychosocial programs. It requires, among other things, an elaborate set of monitoring tools and a monitoring system. Balay is still trying to determine whether it is practically possible to implement such a comprehensive monitoring process. Irrespective of the outcome, promoting stakeholder participation in monitoring remains an approach that is more inclusive and more in tune with the views and aspirations of those most directly affected. Furthermore, stakeholder participation contributes to the enhancement of a program's effectiveness as it provides a clearer picture of what is really happening in the intervention area.

Aside from improving accountability, participatory community-based monitoring enhances the capacities of the community partners. It identifies actions that stakeholders themselves agree to take in improving their conditions. As a learning and enabling process, participatory community-based monitoring stimulates stakeholders to use their collective wisdom and strengths. Moreover, monitoring serves as an activity to sum up and synthesize experiences as well as to enable people to celebrate successes and learn from failures.

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