Mental health care for survivors of torture and conflict

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It is estimated that between 5 and 35 per cent of today's refugees are survivors of torture. Research by the Center for Victims of Torture (CVT) has found that rates are much higher in some specific refugee populations: 69 per cent of men and 37 per cent of women from Oromo refugees resettled in Minnesota in the US have been tortured; 37 per cent of women and 25 per cent of men in the Somali refugee community have experienced torture.[1]

While each conflict has its own story of origin, the violence is distressingly familiar: forced recruitment of children and adults as soldiers; arbitrary arrests, detention and torture; sexual crimes against men, women and children; barbaric rape of women and girls leaving some with extreme and irreparable mutilation; witnessing killings or being forced to kill; kidnapping and human trafficking.

Many survivors rebuild their lives with supportive families and communities. But a significant number will face serious, ongoing symptoms as a result of their torture and war experience. Survivors can live with constant fear, debilitating depression, terrifying nightmares, crippling anxiety and thoughts of suicide. These symptoms can be incapacitating, leaving survivors unable to care for themselves or their families the way they could before.

The Center for Victims of Torture (CVT) is an international non-profit organization dedicated to healing survivors of torture and war. It provides direct care to survivors at its healing centre in Minnesota and at healing initiatives in Africa and the Middle East.

While CVT is one of the largest torture rehabilitation centres in the world, its ability to provide mental health care in a refugee camp or post-conflict nation is overwhelmed by the scale of violence and numbers of survivors. In response to this overwhelming global need, CVT has developed community mental health programmes to provide direct services to those most deeply affected and to develop the capacity of local communities to meet their own mental health needs.

The heart of CVT's international mental health initiatives is training. The training is experiential, with paraprofessional counsellors – recruited from affected communities where possible – learning alongside professional psychotherapists with survivors in individual and group settings.

Peer counsellors undergo an intensive training period and then receive monthly formal trainings and ongoing feedback. CVT always aims to build sustainable healing services for torture survivors. Therefore, training for counsellors is lengthy, hands-on and intensive.

At the community level, CVT conducts large-group activities to raise awareness of the prevalence and effects of torture. Staff work together with teachers, religious figures and other community leaders to identify how they can help others, address community-level conflicts, form a supportive community for healing and identify individuals who might benefit from care.

CVT's collaboration with the community and training of paraprofessional psychosocial counsellors also aim to carefully incorporate positive cultural systems and rituals into evidence-based mental health interventions.

Dadaab, Kenya

In 2011, CVT began to use this model for care and training to provide mental health services in one of the refugee camps located outside Dadaab, Kenya.

The Dadaab refugee complex in north-east Kenya is the world's largest refugee site. The area is dry and dusty, with temperatures usually above 40 degrees Celsius. The sprawling camps are notorious for overcrowding. Designed to house 90,000, they are home to over 460,000 refugees.

In Dadaab the organization provides care for a population of refugees who are primarily from Somalia. Although some humanitarian groups were attempting to address mental health needs, CVT was the first mental health-focused organization to work in the camp since it was built in 1991.

Experience in Dadaab shows that torture and violence among civilian populations in Somalia was widespread and indiscriminate. Many survivors have withstood a number of different traumatic events, including persecution of minority clans by majority clans, and violence by the armed Islamist organization al-Shabaab and the government.

CVT bears witness within the Dadaab camps

to discrimination, harassment and even assault towards minority populations. Most refugees in the camps are from the Somali majority but there are Somali minority groups including Bantu, Benadiri and occupational groups. There is also a small number of refugees from other African countries, including Burundi, the Democratic Republic of Congo, Eritrea, Ethiopia, Rwanda and Sudan.

The stigma assigned to people with mental and physical illness is staggering. In some cases, survivors the camps serve have been ridiculed, harassed and even stoned for having a physical or mental disorder related to their traumatic experiences. Members of minorities who also suffer mental and physical illness face double discrimination.

Women and girls from minority groups are particularly vulnerable in the camps. They are harassed when they go to the market if they are not dressed as the majority group. No female can expect to wear skirts, trousers or uncovered hair without attracting verbal and often physical harassment. Other women have reported that they were not allowed to fetch water or to queue at water points. Efforts are made to prevent women from gathering firewood in the town, so that majority groups can sell the wood for profit.

In 2013, a woman from a minority community was raped and there was suspicion that it was an attempt to intimidate her community and discourage them from taking jobs from the majority. Rape in the Dadaab camps is a common occurrence, with women and children being the most vulnerable to this violence.

Others report that individuals from the majority communities are more likely to be offered employment, and that minority group members are provided with fewer food rations at distribution centres where majority groups are employed and responsible for handing out the rations.

Language is another significant barrier. Since most translators in the camps are from majority groups, this prevents minority groups from interacting and claiming their rights within the camps. This happens when shelter, resettlement or other materials are offered by humanitarian

Left: The Ifo Extension refugee camp in Dadaab, near the Kenya-Somalia border. *REUTERS/Thomas Mukoya.*

groups and the UN refugee agency.

The tenuous security situation in the camps compounds the difficulties of vulnerable groups. One paraprofessional counsellor who had a physical disability was able to work at CVT because a CVT vehicle could transport her to the counselling compound. After attacks on refugee leaders and the kidnapping of aid workers, organizations could not enter the camps except for their own compounds. Unable to get transportation or to walk 5 km, the counsellor was not able to continue working.

Cultural norms also prevent the camps from hiring as diverse a staff as they intend. In Dadaab, it has been difficult for the camps to hire the number of women counsellors they would like to, since the majority culture puts the responsibility of care for the family and children above work outside the home.

At times, not finding translators means survivors seeking our services need to wait before they can receive counselling. While we make every effort to find and train interpreters, limited access to the camps combined with extremely limited resources mean there can be a waiting period.

Minorities who received supportive mental health services from CVT report that they have found a refuge where they can gather strength and courage to withstand the prejudice they cannot escape in the camps. Survivors receiving services from CVT in Dadaab consistently report significant decreases in mental health symptoms such as anxiety and depression, as well as decreases in somatic symptoms. They report increased hope, better coping skills and improved relationships.

Rehabilitative care for minority groups

For minority groups, equal access to mental health care is necessary to rebuild lives and community, and to establish a voice that can advocate for their own rights among the majority population. Unfortunately, the need for mental health care far exceeds available services. CVT and other organizations focusing on mental health are able to provide care to only a fraction of the survivors in need.

Integrating mental health services along with capacity building is one way to scale up care for survivors after conflict and political violence. The paraprofessional psychosocial counsellors employed by CVT gain several years of education, training and direct clinical work. They are ready to serve, but there are no complementary mechanisms in place to support their long-term development to continue this work.

The well-being of traumatized individuals and communities requires both access to mental health services and building of local capacity to provide those services. Counsellors representing minority groups should be an integral part of the process. With experience and training, they can continue to provide care in culturally appropriate ways to members of their community, act as educators about the effects of trauma and participate in the development of community-based approaches to addressing the needs of the community, including pursuit of basic human rights, health and education.

It is understandable that humanitarian aid during and after conflict is focused on basic needs: food, clean water, shelter and medical care. It is also essential to integrate mental health care in support of refugees and during post-conflict rebuilding. When political violence intentionally destroys a community, the society itself must heal before peace and civil society can grow. ■

Endnotes

1. Jaranson, J.M., Butcher, J., Halcon, L., Johnson, D.R., Robertson, C., Savik, K. et al., 'Somali and Oromo refugees: correlates of torture and trauma history', *American Journal of Public Health*, vol. 94, no. 4, 2004, pp. 591–8. Retrieved June 2013, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448304/