

Democratic Republic of Congo Training in Trauma Counseling to Support Victims of Gender-Based Violence

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The Learning for Equality, Access and Peace (LEAP) program is funding a small training course in the treatment of trauma-related disorders for victims of gender based violence.

Over a 3-week period from January to February 2009, 31 Congolese men and women were trained in trauma counseling by a group of five experts hired by the MDRP LEAP program.

The trainees - health and social workers, nurses, and even doctors - were selected in hospitals and health centers in eastern DRC, where the civil population has been most affected by the protracted conflicts and associated violence over the past decade.

In that region, the availability of mental health services for the local population, especially victims of gender based violence (GBV), is scarce. There are no locally-based psychiatrists in the Kivus. Nurses and social workers are overburdened with other duties and lack adequate training to provide much needed psychological support.

The horrific legacy of war

In DRC, rape has been used extensively as a weapon of war. Reports of rapes against women and children, and increasingly men, are common in the eastern provinces. The age range of victims is widening, with not just girls and young women targeted but also small children and older women.



Trainers and participants at the certificate ceremony

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The supervision team on its way to visit workshop participants at their places of work in different health centers.

It is impossible to estimate the extent of gender-based violence in the DRC because it is vastly underreported, as victims lack access to adequate structures, are ashamed or fear reprisal. But since the beginning of the war the number of rape victims is likely to be several hundred thousands.

Support to GBV victims need to address both the psychological impact on the victims as well as the return to their villages, where they face potential stigma: rejection by the husband or the community, rejection of children born as a result of rape. Only with this two-pronged approach will victims be able to return to their normal lives.

Trainers as patients

In Bukavu, participants and trainers met every day over the three-week training period. They heard theoretical lectures (how does the brain work? What is Post traumatic stress disorder - PTSD? How to go about treatment step-by-step?) and had the opportunity to practice what they learned. What is usually role play was very real in this case, as almost all participants displayed trauma symptoms, from depression to full blown PTSD.

“Because we were going to work in the east where conflicts have been going on for so long, I knew that there would likely be some trainees displaying trauma symptoms. But I didn’t know it would be almost all of them. The only other place where I’ve seen this level of psychological symptoms in participants was Kabul”, says Dr. Elisabeth Schauer, one of the five trainers.



Congratulations!

The training team (from left: Nina Winkler, translator Benedict Masimbe, Dr Elisabeth Schauer, Inga Schalinski) with participant Adili Romuald and WB administrator Mass Walimba) during the certificate ceremony

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A “life line” of flowers and stones



“My life - flowers and stones”
Training participant after the therapeutic
lifeline exercise

The main part of the training was devoted to Narrative Exposure Therapy (NET – see box below). This trauma-focused treatment is short — no more than 10 sessions — and aims to help patients to significantly reduce the symptoms of post-traumatic stress disorder and bring back the ability to function again in daily life. Extreme fear or sadness experienced during a traumatic episode changes the structure and functioning of key parts of the brain that store our autobiographic memory. By processing these traumatic events during therapy, the ‘fear structure’ of the memory is broken up and healing begins.

The treatment is visually represented by a cord (life), and flowers and stones placed by the patient at various intervals on the cord to represent the most significant events in their lives. The flowers represent joyful events (birth, going to school) while the stones symbolize frightening or sad experiences (death of someone close, extreme fear, rape).

“Participants who go through this program themselves become the best counselors”, adds Schauer. “This type of learning is very effective in adults, since they need to learn not just from the black board, but by healing their own painful past. The symbols are all given a date, a name and a specific location, which then becomes the ‘roadmap’ for the therapy. Most time is spent on the narration of the biggest stones, which are representative of the traumatic events”

Participants also learned how to screen for PTSD and related trauma disorders, and gained core counseling skills.

At the end of the three weeks, in addition to assessing the participants’ performance during practical exercises, a theoretical exam was administered to evaluate the trainees’ readiness to start practicing what they had learned.



Psychologist Anett Pfeiffer during small
group work

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Support through regular visits

Shortly after the initial training, the trainers visited participants in their place of work to help them with other aspects of trauma counseling such as how to enroll patients, and how to ensure a proper diagnosis. This is essential in order to advise on the correct treatment options.

In March, the trainers returned to DRC to visit the participants and ensure they were comfortable in their new roles as trauma counselors/therapists. They encouraged some of them to practice in duo, with one person listening and the second one taking notes.

The trainers saw their students once again at the end of April. This follow up was important because by then counselors had encountered individual challenges in the provision of treatment, which the trainers could address directly by providing tailored support. Moreover the follow up helped to ensure support from the various institutional and organizational structures involved in service provision.

Schauer explains: *“All of the participants already have a job. This is good because it ensures that they have a regular income, but at the same time we want to make sure that their job descriptions are adjusted to allow them to spend about 50% of their time on trauma counseling. They need to practice regularly to maintain their skills, but we don’t want them to do after their working hours. This is difficult work and takes much energy on the side of the patient as well as the therapist.”*

The results of the small project will be analyzed with a view to expanding it in other locations. The project team also wants to explore the linkages between trauma counseling and socio-economic recovery support.

Post traumatic Stress Disorder and Narrative Exposure Therapy

Post traumatic Stress Disorder (PTSD) is an anxiety disorder that can occur after someone has been through a traumatic event. The word ‘trauma’ is of Greek origin and means ‘wound of the soul’. Clinical psychology defines psychological trauma as the experience and psychological impact of events that are life-threatening or include a danger of injury so severe that the victim is horrified and feels helpless during and shortly after the experience.

After the trauma it is common for victims to have upsetting memories of what happened, to have trouble sleeping, to feel anxious and alert, or to lose interest in things they used to enjoy. For some people these reactions do not go away on their own and may even get worse over time. These people have **post traumatic stress disorder (PTSD)**. PTSD changes the way the brain functions in victims. Stress at the level of trauma can damage the brain in debilitating ways (e.g. seen by a scan).

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Exposure-based treatment and cognitive-behavioral therapy are the most effective ways to treat PTSD.

Narrative Exposure Therapy (NET) has its roots in cognitive-behavioral therapy, exposure therapy and testimony therapy, and it adapts these for populations in resource-poor settings with multiple traumatization. It is a manualized, evidence-based trauma treatment option that encompasses current psychological theories and PTSD treatment approaches and allows the dissemination of the approach to lay-counselors.

The NET-therapist engages in the story of the patient by continuously verbalizing and mirroring sensations, behavior and details of the past in the 'here and now'. S/he is fully accompanying the narrating survivor on all levels of sensations, cognitions, physiological responding, emotions and meaning contents. The therapist's set of mind can be described as empathic and non-judgmental, just like in humanistic therapies (e.g. client-centered therapy). However, the guidance will be directive to confront the fear-spots while narrating chronologically.

Next to the alleviation of trauma symptoms, NET produces a document with the life story of the patient – including experiences of loss, fear, anxiety, joy and hope. Positive life experiences will create awareness of personal resources and coping strategies of the patient.

NET's effectiveness has been confirmed in diverse target groups, for example child and adult refugees in Europe as well as in different African regions, Asian children and adults after war and after the tsunami, ex-combatants in Somalia, widows and orphans of the Rwandan genocide, and child soldiers in Northern Uganda, among others.

For more information on MDRP, please visit www.mdrp.org or contact Chantal Rigaud Communications Officer, MDRP Secretariat, World Bank at info@mdrp.org.