Testimonial therapy

A pilot project to improve psychological wellbeing among survivors of torture in India

Inger Agger, PhD*, Lenin Raghuvanshi, BAMS, Shirin Shabana Khan**, Peter Polatin, MD, MPH***, & Laila K. Laursen, BA*****

Abstract

Introduction: In developing countries where torture is perpetrated, there are few resources for the provision of therapeutic assistance to the survivors. The testimonial method represents a brief cross-cultural psychosocial approach to trauma, which is relatively easy to master. The method was first described in Chile in 1983 and has since been used in many variations in different cultural contexts. In this project the method has been supplemented by culture-specific coping strategies (meditation and a delivery ceremony).

Methods: A pilot training project was undertaken between Rehabilitation and Research Centre for Torture victims (RCT) in Copenhagen, Denmark, and People's Vigilance Committee for Human Rights (PVCHR) in Varanasi, India, to investigate the usefulness of the testimonial method. The project involved the development of a community-based testimonial method, training of twelve PVCHR community workers, the development of a manual, and a monitoring and evaluation (M&E) system comparing results of measures before the intervention and two to three months after the intervention. Twenty-three victims gave their testimonies under supervision. In the two first sessions the testimony was written and in the third session survivors participated in a delivery ceremony. The human rights activists and community workers interviewed the survivors about how they felt after the intervention.

Findings: After testimonial therapy, almost all survivors demonstrated significant improvements in overall WHO-five Well-being Index (WHO-5) score. Four out of the five individual items improved by at least 40%. Items from the International Classification of Functioning, Disability and Health (ICF) showed less significant change, possibly because the M&E questionnaire had not been well understood by the community workers, or due to poor wording, formulation and/or validation of the questions. All survivors expressed satisfaction with the process, especially the public delivery ceremony, which apparently became a "turning point" in the healing process. Seemingly, the ceremonial element represented the social recognition needed and that it re-connected the survivors with their community and ensured that their private truth becomes part of social memory.

Discussion: Although this small pilot study without control groups or prior validation of the questionnaire does not provide high-ranking quantitative evidence or statistically significant results for the effectiveness of our version of the testimonial method, we do find it likely that it helps improve the well being in survivors of torture in this particular context. However, a more extensive study is needed to verify these results, and better meas-

*) Rehabilitation and Research Centre for Torture Victims
Denmark
inger.agger@gmail.com

**) People's Vigilance Committee for Human Rights
Varanasi
India

***) Rehabilitation and Research Centre for Torture Victims
Denmark
rct@rct.dk

ures of ICF activities and participation (A&P) functions should be used. Interviews with human rights activists reveal that it is easier for survivors who have gone through testimonial therapy to give coherent legal testimony.

Keywords: torture, trauma, testimony, psychosocial interventions, cross-cultural psychotherapy, brief therapy, community-based interventions, psycho-legal counselling

Introduction

In many parts of the world where torture is perpetrated, the human rights organizations providing psychosocial and therapeutic assistance to the survivors have few if any staff resources, such as trained psychologists, social workers, or doctors, and are often only able to see the survivors a few times on an individual basis. It is, therefore, important to identify community-based cross-cultural psychosocial interventions methods, which can be implemented by community workers or human rights activists, and which are brief and do not require large staff resources. This article presents a brief therapy method, testimonial therapy, which was explored in a pilot collaborative project between People's Vigilance Committee for Human Rights (PVCHR), in Varanasi, India and the Rehabilitation and Research Centre for Torture Victims (RCT), in Copenhagen, Denmark.

In the following, we first explain why RCT chose to start a project with this particular approach. Thereafter, different ways of dealing with trauma are discussed, including non-western, cross-cultural, and collective methods. Truth telling or testimony falls within this category. The development of the testimonial method is then presented, including the introduction of mindfulness, ceremony and ritual in our version of the testimonial method. The preliminary results are discussed.

Developing knowledge

Included among RCT's mission targets is the collection of new knowledge about the alleviation of human suffering and other consequences of torture.[1] The partner organisations of RCT work in different cultural contexts in various parts of the world. They undertake counselling interventions to assist survivors of torture, but the concept of counselling has different meanings for different organisations.[2]

In the spring of 2007, an RCT team visited a number of human rights organizations in India and found that short-term legal counselling was the rehabilitation method of choice for survivors of torture.[3] Most of the counselling methods observed were, in fact, variations of "psycho-legal counselling", which has been the subject of an in-depth study by RCT and the Indian human rights organization, Jananeethi.[4] Psycho-legal counselling is most frequently performed by individuals with relatively little mental health training.

In psycho-legal counselling, "justice" constitutes the therapeutic entry point and is an important element in the healing process. It, therefore, made sense to apply the testimonial method in India. It is an approach that emphasizes the denunciation of human rights violations and advocacy to obtain justice. The method is also brief and can be used both in individual and community interventions, and by non-professionals with specific training in the methodology. Giving testimony about one's suffering is probably a significant component in the healing of trauma across cultures, whether the frame of reference is psycho-legal, psychodynamic, existential, spiritual, political, cognitive-behavioural, or narrative.

Therapeutic approaches to trauma

There are a great variety of culture-specific

therapeutic approaches to therapy for survivors of traumatic experiences. Wilson[5] asks if "there are culture specific and universal mechanisms to help persons recover from psychological trauma" (p. 14) and wonders how "cultures develop rituals, medical-psychological treatments, religious practices" (p. 13) to assist the survivors. He notes (p. 16) that at present "we do not have standardized cross-cultural treatment protocols for persons suffering from posttraumatic syndromes".

Clancy & Hamber[6] ask what constitutes "best practice" for cross-cultural psychosocial interventions and note that "psychosocial, rather than psychotherapeutic, approaches are often better suited to address the 'extreme traumatisation' brought about by political violence" (p. 2). Extreme politically motivated trauma is not just a health problem, but also a socio-political problem, and Posttraumatic Stress Disorder (PTSD) is just one language of suffering among many others. These authors find that a rights-based approach can facilitate grieving and mourning processes through its fact-finding and testimonial methods, but will need to be complemented by political advocacy, grassroots and government initiatives, and culture-based therapeutic approaches. They define psychosocial projects as:

"…those which explicitly recognize the link between social agency and mental health through the utilization of a medical and/or psychological intervention to promote a social end, and/or a social, cultural or political intervention that promotes medical and/or psychological wellbeing". (p. 19)

Sales & Beristain[7] suggest that because in Latin America, the centre of social life is in the family and the community, trauma should be understood from this perspective. They cite the importance of the various victim movements, such as the Association of Family Members of the Disappeared. Political violence causes social trauma, which is an "imprint on the collective identity of a people"(p. 15). The significance of Truth, the fight for Justice and Reparation are important aspects of a peace process and involve the whole community.

In recent decades in South Asia, Western trained psychiatrists have dominated the treatment of emotional distress with a medicalised approach. Shah[8] suggests that the incorporation of culturally specific South Asian "technologies of the self",[9] such as yoga, meditation, pranayama, and ayurveda guided by spiritual teachers can promote healing. Sonpar[10] emphasizes the need to understand trauma induced distress from a non-western perspective. She suggests[3] that spirituality and religion have been neglected in the western understanding of trauma, and that religious beliefs, prayer and pujas are important coping strategies (p. 16). She also finds that Narrative Exposure Therapy (NET),[11] in which testimony is an important component, has the advantage of being a brief therapy and a technique for which non-professionals may be trained in situations in which professional help is limited.

Igreja[12] has shown that protracted civil war in Mozambique has profound and traumatic consequences for individuals, families and communities, and that suffering is collective in cultures with a community oriented self in contrast to cultures oriented toward an independent self. In these community oriented cultures, the suffering is not seen as an individual medical "illness" (such as PTSD) but as a social experience (social trauma), which requires a collective approach to promote healing.

According to Hamber,[13] coming to terms with human rights violations requires a dis-

tinction between healing or reparation at the individual or micro-level, and the granting of reparations at the societal or macro-level. It "is difficult to measure, if not impossible to satisfy" (p. 564) whether reparations at the macro-level lead to reparation at the micro-level. Lykes & Mersky[14] have criticized a purely biomedical approach to survivors of organised violence, and suggest that questions of justice and truth must also be addressed. They see narrative, testimony, truth telling, and story telling as important resources for understanding and accompanying the survivors.

Development of the testimonial method

In the version of testimonial therapy developed for this project, an attempt has been made to include a meditative, and ceremonial element (an "honorary delivery ceremony" in which the survivor receives his or her written testimony) so as to reinforce a culturally sensitive aspect of the method. Survivors of torture are often lonely and isolated from their community, group, friends and family. They feel that their dignity has been destroyed by a police force that has stigmatized them as "criminals". They badly need to regain their dignity and honour through a form of social recognition in which their private truth is openly recognised and becomes public truth, and their suffering is acknowledged and becomes part of social memory. A general silence often surrounds political repression, as if it only exists in the minds of the survivor, but the narratives of the survivors will preserve history.[15] It is the hypothesis of this project that the ceremonial element represents the social recognition needed and that it re-connects the survivors with their community and ensures that their private truth becomes part of social memory.

Testimony therapy was first described in 1983 when two Chilean therapists[16] writing under pseudonyms presented and analysed testimony as a specific therapeutic technique used with torture victims and their relatives. The testimony was tape-recorded by the therapist and revised jointly by therapist and patient into a written document. The aim of the testimony was to facilitate integration of the traumatic experience and restoration of self-esteem. However the authors note that, "communication of traumatic events through testimony may also have been useful (…) because it channelled the patients' anger into a socially constructive action – production of a document that could be used as an indictment against the offenders. The possibility of putting their experiences to use resulted in the alleviation of guilt" (p. 50).

The method was further described in 1990 as a ritual both of healing and of condemnation of injustice. "When political refugees give testimony to the torture to which they have been subjected, the trauma story can be given a meaning, can be reframed: private pain is transferred into political dignity"[17] (p. 115).

A 1992 textbook on counselling and therapy with victims of war, torture and repression[18] recommends the testimony method as a brief psychotherapy for motivated clients, or as a supplement to other treatment approaches for clients with multiple problems besides the sequelae of torture.

In 1994, a research project studying psychotherapeutic treatments for women victims of sexual torture[19] utilized the testimony method, and in 1996 testimony was studied in a Chilean context as a therapeutic tool developed in the political framework of an active human rights movement during the Pinochet dictatorship.[20]

In 1998 the testimony method was studied in a South African context where

public testimony constituted the central mechanism in the South African Truth and Reconciliation Commission (TRC) process.[21] The authors locate the testimony method within the broad framework of social constructionism and they find that "thematic analysis revealed that … overall, the narratives affirmed the therapeutic value of the testimony method", and "the connectedness between individual healing and national reconciliation" (p. 257).

The same year, the testimony method was utilized with a group of traumatised Bosnian refugees[22] and provided "preliminary evidence that testimony psychotherapy may lead to improvements in PTSD and depressive symptoms, as well as to improvement of functioning in survivors of state-sponsored violence" (p. 1720).

In 2002 Narrative Exposure Therapy (NET), integrated by components from the testimony method and cognitive behaviour therapy, was utilized with a small group of severely traumatized Kosovar refugees.[23] The conclusion was that this case study "indicates that Narrative Exposure is a promising and realistic approach for the treatment of even severely traumatized refugees living in camps. In addition, it can provide valid testimonies about human rights violations without humiliating the witness" (p. 205).

In the Netherlands, the testimony method has been applied in the treatment of traumatized asylum seekers and refugees.[24] The therapy, consisting of 12 sessions, is described step-by-step and the working mechanisms of the testimony method are reframed in cognitive-behavioural terms, as "exposure to the traumatic memories, as well as the adjustment of inadequate cognitions" (p. 368-9).

In 2003 in Germany, a testimony project for traumatized Bosnian refugees living with uncertain asylum status for many years was carried out in which the testimony method was used in combination with supportive therapy and advocacy.[25] The authors concluded that "by giving testimony, survivors benefited psychologically and became better able to cope with the difficult present. Feelings of self-worth and dignity could be regained and a trusting relationship between the survivor and the listener facilitated the therapeutic process. The testimony material documented human rights abuses both in the country of origin and in exile, helped us to perform informed advocacy for this group and informed a larger public on the psychological costs of refugee resettlement policies" (p. 393).

In 2004 the effectiveness of the testimony method was explored in a rural community in Mozambique with survivors of prolonged civil war.[26] The study included an intervention group (n=66) and a control group (n=71) and trauma symptoms were measured during a baseline assessment, post-intervention and at an 11-month follow-up. A simple version of the testimony method was applied with only one session for most participants. It is concluded in the study that, "a remarkable drop in symptoms could not be linked directly to the intervention. Feasibility of the intervention was good, but controlling the intervention in a small rural community appeared to be a difficult task to accomplish" (p. 251). Concerning clinical implications of the study, the authors find that the "introduction of the testimony method in a relatively small and isolated rural community was feasible and associated with the decrease of reported psychiatric symptoms" (p. 257).

In the same year, testimonial therapy was used with traumatised Sudanese adolescent refugees in the United States who lacked experience with or interest in psychiatric care.[27] "Testimonial psychotherapy's unique

focus on transcribing personal, traumatic events for the altruistic purpose of education and advocacy make it an acceptable interaction by which to bridge the cultural gap that prevents young refugees from seeking psychiatric care" (p. 31).

Also in 2004, a study was published comparing Narrative Exposure Therapy (NET) with supportive counselling and psycho-education for the treatment of Sudanese refugees living in a Uganda refugee settlement.[28] "The results indicated that (it) was a promising approach for the treatment of PTSD for refugees living in unsafe conditions".

In 2005 the testimony method was also used for injured humanitarian aid workers who had survived the bombing of the UN Headquarters in Iraq.[29] The method was found to be an effective tool: "The testimony method provided a safe structure to recall the traumatic event, while assisting in the reconstruction of the traumatic memories and associated emotions, and offered an acceptable motivation to do so" (p. 57).

Also in 2005, testimony therapy was reframed[30] as "an African-centred therapy that focuses on the personal stories of those who consult with the therapist, as well as the collective stories of the African experience in the United States" (p. 5). In this narrative approach "testimony therapy emphasises the person within community and is social constructionist in its outlook" (p. 5).

The same year, Schauer, Neuner and Ebert published a systematic analysis and manual on the use of testimony in Narrative Exposure Therapy (NET),[31] reviewing their theoretical background for understanding traumatic stress and the cognitively oriented therapeutic approach of NET.

Including meditation, ceremony and ritual in the testimonial method

The importance of cultural rituals and ceremonies for survivors of torture and organized violence (TOV) has also been emphasised by Somasundaram,[32] who addresses the many problems following the exposure to conflict, war and disaster in Sri Lanka. The multi-level community approaches needed when assisting these survivors include (p. 19): Encouragement of indigenous coping strategies, support of cultural rituals and ceremonies, and community interventions (including support groups and the use of expressive methods).

Somasundaram describes how culturally appropriate relaxation exercises can be taught to large groups in the community. These originally spiritual practices, such as meditation not only reduce stress, but also "tap into past childhood, community and religious roots and thus release a rich source of associations that can be helpful in the healing process" (p. 20). The holistic approach represented by the traditional relaxation methods work at the physical, mental, social and spiritual levels, promoting wellbeing and mental health.

Mindfulness-based stress reduction (MBSR)[33] and mindfulness-based cognitive therapy (MBCT)[34] have developed in the U.S over the last twenty years, and have good empirical support for their effectiveness. MBSR and MBCT are inspired by Eastern traditions such as Buddhist meditation and yoga. Mindfulness is defined by Kabat-Zinn as: "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally"[35] (p. 4). Mindfulness has proved effective for "narrative integration", whereby the life story is "weaved together" in a process of "reflection and neural integration" [36](p. 309-10).

Community-based psychosocial and psycho-legal work in India

People's Vigilance Committee for Human Rights (PVCHR) in Varanasi was started in 1996 as a membership based human rights movement. It operates on the grass-root level in 45 villages in Uttar Pradesh, one of the most traditional, conservative and segregated regions in India. Human rights activists in the villages work as volunteers with PVCHR and document cases of severe human rights violations.

PVCHR works to ensure basic rights for vulnerable groups in Indian society, e.g. children, women, Dalits and tribes, and to create a human rights culture based on democratic values. One of the severest violations of human rights in India is the widespread use of torture in police custody, which is closely linked to caste-based discrimination. In crime investigation suspects are tortured to force confessions. There is no independent agency to investigate cases, so complaints are often not properly reviewed and perpetrators are not prosecuted and punished. PVCHR investigates and documents human rights violations, and, in cases of custodial torture, also provides legal aid. To raise public awareness PVCHR is co-operating with media as well as national and international human rights networks. It also requests that local authorities initiate action to prevent further human rights abuses. The documentation is used for advocacy, and is published through local, national and international organizations.

PVCHR helps provide education in the villages, reactivating defunct primary schools, encouraging the education of girls and promoting non-formal education to bridge the gap between marginalized children and children in government schools. PVCHR also focuses on organizational development of vulnerable groups and the implementation of village committees. In some of the villages a community centre has been established, forming the base for development activities. People are also actively engaged in community-based counseling, in the form of "Folk Schools", one of the core activities in the model villages. In community meetings of the Folk Schools *people can testify about their suffering and receive support from the group.* Folk Schools also deal with conflicts with the village head or experiences of torture. Special forums for women focus primarily on health, but sometimes include such things as dowry issues. The statements of the villagers are recorded and their demands are forwarded to administration and governments.

PVCHR has been a key partner in the European Union (EU) and Friedrich Neumann Stiftung supported the "National Project on Preventing Torture in India" which was implemented by People's Watch Tamil Nadu. The aim of the project, 2006-2008, was to initiate and model a national campaign for the prevention of torture in India, with a deliberate focus on torture practices employed by police. The project was carried out in nine states.

Methods

Development of a specific testimonial therapy model

The testimonial method is not one, well-established method, but has been used in many variations and settings as described above. Usually its brief format has had the objective of alleviating symptoms, helping the survivor to re-establish emotional and social bonds and recover his or her resources. The testimony can be seen as a "map of pain" on which survivors can recover their history, working with chaotic fragments of memory of the past experienced as a traumatic present.[15]

For this project, a new version of the

method was developed containing the following key elements:

1. A brief format (only 3-4 sessions).
2. Non-professional therapists (human rights activists or community workers).
3. Teams of therapists (one interviewer, one note taker).
4. A public or community-based delivery ceremony (normally in the third session).
5. Mindfulness/meditation included at the beginning or end of the first two sessions;
6. A context-specific manual to guide the teams.
7. A monitoring and evaluation system included in the testimony process.
8. A ten days training course for the therapists, with five days of theory and five days of supervision while taking testimonies with survivors.

The testimonial procedure

The testimonial therapy procedure in this model is performed over four sessions:

– Session one: Opening the story
– Session Two: Closing the Story
– Session Three: The delivery ceremony
– Session Four: Follow-up.

The testimonial method can be used with survivors of torture only if they have complete *trust* in the therapists. Therefore, the therapists must be part of an organization the survivors already know and with which they have established a bond of trust. This will most likely be a human rights organization, which has already made legal testimonies with the survivors and supported them in their fight for legal justice and reparation.

The duration of each session is normally from 90 to 120 minutes. The survivor should be informed before the session starts about the number and duration of the sessions. The first and second session includes a meditation ("mindfulness") experience guided by the therapists, in which the survivor and the two therapists sit together for ten minutes in silent concentration on their breathing and with awareness of their thoughts and feelings. The meditation will usually take place at the end of a session.

The testimony is written in note form by the note taker during the sessions. After the sessions, the interviewer and note taker collaborate on filling-in the missing parts of the story and produce a computer version of the narrative. The story in the written testimony is in the first person ("I experienced", and not "he experienced"). The story about the traumatic events is in the past tense, while sensations and feelings produced by telling the story are in the present tense. In the training course, the steps for writing a good testimony is explained and practiced. A testimony should include detailed information about the torture experience, the perpetrator(s), emotional reactions of the survivor to the experiences at the time when it happened and now, the impact of the torture on the survivor's life (impact on relation to family and community), and the steps taken by the survivor to obtain justice.

Session One: opening the story[a]

When starting the first session the testimony procedure is explained, beginning with a psycho-educational introduction to the survivor in which his or her symptoms are explained both as a result of the torture and of the violation of universal human rights, which has taken place. A preparatory introduction to the therapeutic approach is given: the testimony should not be seen by the survivor as directly related to expectations of obtaining immediate justice and reparation but as a way of healing the psychological effects of the torture. Then the M&E ques-

tionnaire is completed, and it is explained that the data are confidential and will only be used for developing methods for helping survivors of torture.

The survivor is then asked to give a short description of personal background and individual history prior to the first traumatic event or persecution. With open questions the survivor is asked to briefly describe the stressful events s/he has experienced and choose one major, overwhelming traumatic event. The therapist gives an overview of the different events to help the survivor trace one of the experiences and help him/her really begin the re-construction of the story. The therapist separates overlapping stories (if the survivor wants to tell about more than one event). The therapist organizes the themes and helps the survivor to explain unclear elements in the story. It is important that the therapist is "in control" of the situation and leads the survivor in getting to the main points of the story. The survivor narrates the facts concerning this event (time, place, duration and people involved), the survivor's role during the event (observer, participant, active or passive), the individual and social dimensions of the experience, the survivor's perceptions and feelings at the time of the event, and the survivor's perceptions and feelings at the time of the testimony therapy.[26] The therapists (interviewer and note taker) are empathic and warm. Contradictions are clarified, and the survivor is urged to describe the torture in as much detail as possible and to disclose his or her emotions and thoughts at that moment. The therapists may use culturally appropriate touch, e.g. a hand on the arm of the survivor. A mindfulness meditation experience ends the session.

Session Two

One of the therapists starts the second session by reading the written testimony to the survivor in a loud voice so that the survivor hears that his or her story has been given voice. It often has a strong supportive effect on the survivor to hear his or her story of suffering told with another voice. The survivor is asked to correct the story or add any additional details that may have been missed, and the therapists continue the session as during the first session. They focus on the relationship between the stressful experience and the present situation and the survivor is encouraged to express his or her feelings about the future (individual, family and community). A mindfulness meditation ends the session. After the session, the therapists correct the document to produce a final version of the testimony.

Session Three: the delivery ceremony

The delivery ceremony can be performed in different variations according to the wishes of the survivor and the circumstances: a public ceremony (with a wider audience in the streets) or a more private ceremony (with the community, support group or family), a political ceremony (a demonstration), or a spiritual ceremony (with emphasis on cultural ritual and purification). In the ceremony, the interviewer (or note taker) reads the testimony out to the audience, and the survivor is presented with a printed copy of his or her testimony. Speeches could be given praising the courage of the survivor, who might be awarded flower garlands or some other symbol of honour.

In this project, PVCHR held a public delivery ceremony in honour of the survivors. The ceremony was also a political demonstration against torture and was held in front of the District Government Headquarter of Varanasi where 14 testimonies were read out in public and delivered to the survivors who were also honoured with a cotton shawl

(a symbol of honour in India) and a speech which praised their bravery and encouraged them to continue fighting for justice. Many of the survivors and their family members cried when they heard their stories read out, and said afterwards that they felt very happy. At the end of the ceremony the 14 survivors spontaneously sat down in a circle and spoke with each other about their feelings. The ceremony was transmitted by local TV networks and written about in the press.

Session Four: follow-up

The fourth session is a post-therapy testing to monitor and evaluate the outcome of the testimony therapy. One of the therapists meets with the survivor one to two months after the last intervention (public ceremony, community meeting, or delivery of the testimony), and the M&E questionnaire is filled-in.

Development of a training course in testimonial therapy

The participants in the training course were human rights activists and community workers from PVCHR. The workshop was divided into two main parts with an equal balance between theory and practice: 1. five days of theoretical input, and 2. five days of practical work. The theoretical part contained both theory and role play exercises in which the participants worked with communication ("active listening"), the filling in of questionnaires, the interview process and the group process. During the second part of the workshop, the participants took testimonies from survivors and received supervision and feedback.

Development of a monitoring and evaluation system

The questions that constituted the M&E were derived from a standardized instrument, WHO-Five Well-being Index (WHO-5),[37] from the application of International Classification of Functioning, Disability and Health (ICF) Activities & Participation categories,[38] and from the utilization of items from standardized questionnaire information already in use by PVCHR. The experiences of the RCT epidemiologic field study in Bangladesh, recently conducted by Dr. Sharlenna Wang,[39] were also reviewed. The M&E questionnaire was formulated in Copenhagen, but translated and contextualized in Varanasi.

Results

Twelve human rights workers from PVCHR were trained by RCT through an interpreter. The ages of the trainees ranged from 24 to 38 years. Six of them were male, and four were female. Six of the participants had an MA degree (in social work, sociology, history or human rights); three had a BA (in ayurvedic medicine, sociology or Hindi); and three had an intermediate school education. Seven understood English, and three spoke it well. Two did not understand any English.

The trainees collected 23 testimonies as part of the training in a supervised process. The 23 torture survivors who gave their testimonies were known to PVCHR. They had all previously given legal testimonies for use in court cases against the perpetrators (mostly the police). They were selected out of a group of approximately 80 clients of PVCHR because they had shown evidence of psychological distress. Nineteen of the twenty-three were male, and two belonged to the upper castes, while 13 belonged to the "backward" castes and eight to the "scheduled" castes. Twenty-one of the twenty-three were Hindus, while 1 was a Muslim and another was a Buddhist. There were 17 primary victims, and six secondary victims.

A manual for community workers and

human rights defenders in Uttar Pradesh, India on how to use the testimonial method was developed in collaboration with PVCHR.[40] The manual has been illustrated by a local artist and it has been distributed to a large number of human rights organisations in PVCHR's network and has also been posted on the RCT international website. The manual has been translated into Hindi and was published in Varanasi in January 2009. An English edition will be published in the RCT Praxis Paper Series.

Results of monitoring and evaluation process

The majority of the individuals who participated in this pilot study were primary victims of torture (17 out of 23, 74%).[b] Prior to participation in testimonial therapy, most victims were having difficulties functioning under stress. Many were able to work and support themselves with mild to moderate difficulty, but all had been doing better before they were tortured and had much more difficulty with income generating activities immediately after being tortured. Quite a few had residual pain (high pain analog), and a low sense of wellbeing (low WHO-5 score). Many of them had three or more residual psychological symptoms subsequent to the torture event. Many did not understand the issue of basic human rights, or could not appropriately answer questions about issues related to politics and human rights. Most of them had received very low levels of health care after they had been tortured, even though many of them had experienced fairly extensive physical injuries. All had seen an attorney, reflective of the fact that they were involved with the PVCHR.

After testimonial therapy, almost all survivors demonstrated significant improvements in overall WHO-5 score (pre-therapy average 7.7; post therapy average 14.9). Four out of the five individual items improved by at least 40%.

ICF items showed less significant change, possibly because the M&E questionnaire had not been well understood by the community workers and/or survivors. This is a common problem while working with questionnaires not validated to a specific context or culture. The questions that are derived from work done by western researchers might not be applicable to non-western populations. In the effort to get a more reliable clinical assessment, the questionnaire may have been too schematic in its design, resulting in many invalid answers. Because it was not field tested prior to use in the pilot study, the pilot study was the field test for the finalized M&E questionnaire, and it revealed certain problems with the questionnaire. Nevertheless, certain trends were noted. "Handling stress and other psychological demands" (D-240) demonstrated a trend toward improvement after therapy (i.e., a shift from "complete" or "moderate" difficulty toward "mild" or "no" difficulty). There was no decrease in the number of psychological symptoms (asked as items on a checklist) after therapy, but more sensitive psychological measures were not employed. However, the results are not statistically significant.

Spontaneously, all survivors expressed satisfaction with the process of therapy, especially the public delivery ceremony.

Discussion

This pilot study suggests that testimonial therapy adapted to a local context provides benefit to survivors of torture, as reflected by improvements in a measure of wellbeing as well as by informal interviews with the therapists and survivors. It is admittedly a preliminary project with a small number (23), and without a control group. The

monitoring and evaluation questionnaire demonstrated certain shortcomings and therefore did not provide high-ranking quantitative evidence for the effectiveness of our version of the testimonial method. However, feedback from the therapists and note takers who participated in the study supports our impression of the cross-cultural applicability and effectiveness of the testimonial model developed in the collaboration between PVCHR and RCT during this project. The integration of meditation, yoga and mindfulness in the testimonial therapy needs to be further developed.

Usually the justice process in India takes more than ten years, and many plaintiffs who are survivors of torture become discouraged and give up. However, our interviews with the survivors who had gone through testimonial therapy suggested that they felt more confident in pursuing their claims. The therapy appeared to have created new dynamics in the justice process. In some cases the pain and the agony expressed in the testimonies helped convince the judiciary and human rights institutions of the injustice committed against the plaintiff. An investigator from an international human rights organisation who, coincidentally, interviewed some of the survivors that had completed testimonial therapy, observed that it was easier to elicit a coherent story from them and it seemed less painful for them to narrate the torture story.

Twenty-two of the twenty-three survivors participating in the study have become involved in the human rights movement, supporting other survivors, participating in demonstrations, and telling their stories in community meetings.

However, a more extensive study is needed to verify these results, and better measures of ICF A&P functions should be used with a preliminary field test after contextualization and more intensive training in the use of the M&E questionnaires. Testimonial therapy offers a brief format to access a population in need. It can be delivered by trained non-professional personnel, and can contribute to improved emotional well being as well as better documentation of human rights abuses.

References

1. RCT policy: RCT challenges and targets in a changing world. Copenhagen: Rehabilitation and Research Centre for Torture Victims, 2004.
2. Olsen JS, Haagensen JO, Madsen AG et al, eds. From counseling to psychosocial development: an anthology. Copenhagen: Rehabilitation and Research Centre for Torture Victims, 2006.
3. Haagensen JO, Agger I, Wendt E. Second fact finding mission to India: New Delhi, Gujarat and Uttar Pradesh, 26 March-3 April 2007. Copenhagen: RCT Report, 2007.
4. Agger I, Ansari F, Suresh S et al. Justice as a healing factor: psycho-legal counseling for torture survivors in an Indian context. Peace and Conflict: J of Peace Psychology 2008;14:315-33.
5. Wilson JP. The lens of culture: theoretical and conceptual perspectives in the assessment of psychological trauma and PTSD. In: Wilson JP, Tang CS, eds. Cross-cultural assessment of psychological trauma and PTSD. New York: Springer, 2007:3-30.
6. Clancy MA, Hamber B. Trauma, peacebuilding, and development: an overview of key positions and critical questions. Draft discussion paper presented at the Trauma, Peacebuilding and Development Roundtable hosted by INCORE and the IDRC, New Delhi, 9-11 September 2008.
7. Sales PP, Beristain CM. Trauma, development and peacebuilding: a Latin American perspective. Draft discussion paper presented at the Trauma, Peacebuilding and Development Roundtable hosted by INCORE and the IDRC, New Delhi, 9-11 September 2008.
8. Shah SA. Ethnomedical best practices for international psychosocial efforts in disaster and trauma. In: Wilson JP, Tang CS, eds. Cross-cultural assessment of psychological trauma and PTSD. New York: Springer, 2007:51-64.
9. Foucault M. Technologies of the self. In: Martin LH, Gutman H, Hutton PH, eds. Technologies of self: a seminar with Michel Foucault. Amherst: University of Massachusetts Press, 1988.

10. Sonpar S. Trauma, development and peacebuilding. Cross-regional challenges: South Asia. Draft discussion paper presented at the Trauma, Peacebuilding and Development Roundtable hosted by INCORE and the IDRC, New Delhi, 9-11 September 2008.
11. Schauer M, Neuner F, Elbert Th. Narrative exposure therapy: A short-term intervention for traumatic stress disorders after war, terror, or torture. Gottingen: Hogrefe Verlag, 2005.
12. Igreja V. The monkey's sworn oath. Cultures of engagement for reconciliation and healing in the aftermath of the civil war in Mozambique. Leiden: University of Leiden, doctoral thesis, 2007.
13. Hamber B. Narrowing the micro and macro: a psychological perspective on reparations in societies in transition. In: de Greiff P, ed. The handbook of reparations. Oxford: Oxford University Press, 2006:560-88.
14. Lykes MB, Mersky M. Reparations and mental health: psychosocial interventions towards healing, human agency, and rethreading social realities. In: de Greiff P, ed. The handbook of reparations. Oxford: Oxford University Press, 2006:589-622.
15. Lira E. Human rights and political reconciliation: political and ethical dilemmas. The case of Chile. Lecture at conference: Peace psychology and protection of vulnerable groups – psychosocial risk reduction and recovery. Copenhagen: University of Copenhagen, 30 January 2009.
16. Cienfuegos AJ, Monelli C [Elizabeth Lira, Fanny Pollarollo]. The testimony of political repression as a therapeutic instrument. Amer J Orthopsychiat 1983;53: 43-51.
17. Agger I, Jensen SB. Testimony as ritual and evidence in psychotherapy for political refugees. J Trauma Stress 1990;3:115-30.
18. Van der Veer G. Counseling and therapy with refugees: psychological problems of victims of war, torture and repression. West Sussex, UK: John Wiley & Sons Ltd, 1992.
19. Agger I. The blue room. Trauma and testimony among refugee women – a psychosocial exploration. London: Zed Books, 1994.
20. Agger I, Jensen SB. Trauma and healing under state terrorism. London: Zed Books, 1996.
21. De la Rey C, Owens I. Perceptions of psychosocial healing and the Truth and Reconciliation Commission in South Africa. Peace and conflict: Journal of Peace Psychology 1998;4:257-70.
22. Weine SM, Kulenovic AD, Pavkovic I et al. Testimony psychotherapy in Bosnian refugees: a pilot study. Am J Psychiatry 1998;155:1720-6.
23. Neuner F, Schauer M, Roth WT et al. A narrative exposure treatment as intervention in a refugee camp: a case report. Behavioral and Cognitive Psychotherapy 2002;30:205-9.
24. Van Dijk JA, Schotrop MJA, Spinhoven P. Testimony therapy: treatment method for traumatized victims of organized violence. Am J Psychother 2003;57:361-73.
25. Luebben S. Testimony work with Bosnian refugees: living in legal limbo. Br J Guid Counc 2003;31:393-402.
26. Igreja V, Kleijn WC, Schreuder BJN et al. Testimony method to ameliorate post-traumatic stress symptoms: Community-based intervention study with Mozambican civil war survivors. Br J Psychiatry 2004;184:251-7.
27. Lustig SL, Weine SM, Saxe GN et al. Testimonial psychotherapy for adolescent refugees: a case series. Transcult Psychiatry 2004;41:31-45.
28. Neuner F, Schauer M, Klaschik C et al. A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. J Consult Clin Psychol 2004;71:579-87.
29. Curling P. Using testimonies as a method of early intervention for injured survivors of the bombing of the UN headquarters in Iraq. Traumatology 2005;11:57-63.
30. Akinyela MK. Testimony of hope: African centered praxis for therapeutic ends. Journal of Systemic Therapies 2005;24:5-18.
31. Schauer M, Neuner F, Elbert Th. Narrative exposure therapy: a short-term intervention for traumatic stress disorders after war, terror, or torture. Gottingen: Hogrefe Verlag, 2005.
32. Somasundaram D. Collective trauma in northern Sri Lanka: a qualitative psychosocial-ecological study. Int J Ment Health Syst 2007;1:1-27. www.ijmhs.com/content/1/1/5.
33. Kabat-Zinn J. Full catastrophe living: using the wisdom of your body and mind to face stress, pain, and illness. New York: Dell Publishing, 1990.
34. Segal ZV, Williams JMG, Teasdale JD. Mindfulness-based cognitive therapy for depression: a new approach to preventing relapse. New York and London: Guilford Press, 2002.
35. Kabat-Zinn J. Wherever you go, there you are: mindfulness meditation in everyday life. New York: Hyperion, 1994.
36. Siegel DJ. The mindful brain: reflection and atunement in the cultivation of well-being. New York and London: W.W. Norton & Company, 2007.

37. WHO-Five Well-being Index (WHO-5). www.who-5.org.
38. International classification of functioning, disability and health. Geneva: World Health Organization, 2001.
39. Personal conversation between Dr. Sharlenna Wang and Dr. Peter Polatin.
40. Raghuvanshi L, Agger I. Giving voice: using testimony as a brief therapy intervention in psychosocial community work for survivors of torture and organised violence. Copenhagen: Rehabilitation and Research Centre for Torture Victims, Praxis Paper Series (in press). Hindi version published in Varanasi, 2009.

Notes

a. Part of the procedures in Session One and Session Two has been inspired by Narrative Exposure Therapy (NET)[31] and Igreja et al.[26]
b. As the sample size is relatively small, the results will be expressed in qualitative terms. Most of the results are not significant on a 5%-level due to the small sample size.