Evaluating psychosocial group counselling with Afghan women: is this a useful intervention?

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Abstract
Data from 109 Afghan women participating in psychosocial counselling groups was analyzed to measure the groups' effects on their lives. Most participants were survivors of war-related forms of violence. Others had experienced domestic violence and some were still living under abusive circumstances while attending counselling. The evaluation took place in the group setting and each participant was asked to answer a standardized set of four open-ended questions. All answers were tabulated, coded and eventually put into themes to be analyzed. Over 90% of the participants described an improvement in their social life or their general health. This research shows that this model of psychosocial care is a useful intervention to assist Afghan women suffering from a variety of physical or emotional problems.

Keywords: psychosocial counselling, women in Afghanistan, psychological trauma, sexual violence, domestic violence

Introduction
In 1995 the United Nations Special Rapporteur on Torture recognized rape as a traumatic form of torture for the victim.[a] Presently, sexual violence against women in war and conflict is regarded as a severe violation of human rights under international humanitarian law.[1] Perpetrators of torture focus not only on the physical and psychological aspects of their victims but also attack their economic, social and cultural worlds. Consequently, survivors often suffer from a variety of mental health problems.

Afghan women have been affected by nearly 30 years of war in their country and the subsequent destruction of their lives, families and communities.[2] Over these years they experienced political and military acts of violence that affected them deeply. Additional to the devastating effects of war, Afghan women have lived, and still live, in a volatile and patriarchal society that has made them targets of specific kinds of violence, namely domestic, social and sexual violence.[3] These kinds of violence are used as tools of oppression and may include physical confinement, forced and child marriage, rape, torture, abduction and murder.[4]

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a) In certain countries, rape and other forms of sexual assault were reported to be common means of torture. In some instances, the gender of an individual constituted at least part of the very motive for torture itself, such as in those where women were raped allegedly for their participation in political and social activism.[18]

One of the many objectives of torture is to destroy the psychological and social integrity of the victim. In Afghanistan, women who have been raped or have experienced any form of sexual or sexualized violence suffer from extreme anxiety and shame. If the violation is known to others, they are also exposed to severe forms of stigmatization and are at risk of getting killed as they are perceived to have destroyed their families' and patrilineages' honour. Thus, perpetrators use sexual violence intentionally and as a weapon of war to affect not only the individual victim but also her family and community.[b]

Participants of the evaluated psychosocial counselling groups typically suffer from a range of mental health conditions. These range from chronic headaches to self-mutilation and suicidal behaviour. Several studies point out the high level of mental health problems as presented by Afghan citizens[5,6] but particular populations seem to present with higher levels of vulnerability. These include children[7] internally displaced people and refugee populations.[8,9]

Most Afghan women are still lacking basic health care services[c] and very limited mental health services are only available in the major centres. An extremely small number of professionals are able to provide qualified psychosocial and mental health services.[d] One of the few service delivery and training agencies currently operating in Afghanistan is medica mondiale.

Medica mondiale's activities in Afghanistan

Medica mondiale is an international non-governmental organization whose base of operation is located in Germany (www.medicamondiale.org). The organization was founded in 1992 and supports women and girls who have been sexually violated during war and civil conflict. It also provides services for women affected by other forms of gender-based violence in post-war and conflict zones.[e] medica mondiale uses a holistic, multidisciplinary and women-centered approach. Direct services, training of professionals and political lobby and advocacy work for women's rights are characteristics of medica mondiale's strategies.

Medica mondiale initiated services for traumatized women and girls in Afghanistan in 2002. Today medica mondiale's Afghanistan program has a multidisciplinary team providing psychosocial counselling, medical and legal advice and support for beneficiaries, lobbies for women's rights and trains professional women. All of the program components are available in Kabul and some are provided in Mazar-e-Sharif, Herat and Kandahar. In 2004, group counselling services began in five districts of Kabul and to date about 350 women have participated in psychosocial counselling groups. Additionally, medica mondiale staff trained and is training educated and professional women as counsellors to facilitate individual and group counselling.

b) For further information related to the background of war rape and its consequences for women see[19]

c) Life expectancy rates for men and women are 41 and 44 years respectively. The national infant mortality ratio is 25.7%. It is higher in certain provinces. The maternal mortality rate is at 1,900 deaths in 100,000 live births, and overall the country's health conditions are among the worst in the world.[20]

d) See e.g.[8,21]

e) medica mondiale built and supports women's psychosocial and counselling and training centres in Bosnia and Herzegovina, Albania, Kosovo, Afghanistan, Liberia and DR Congo and supports small scale psychosocial projects for women affected by violence in Cambodia, East Timor, Iraq, Israel, Nepal, Mexico, Sierra Leone, South Africa, Turkey and Uganda.

Psychosocial care

The term psychosocial care entails a range of psychological and social services that support individuals and communities in need of mental health services. This includes any intervention from supporting a person in need of counselling to teaching specific skills to finding employment. In the general field of psychology this may entail stabilizing a person in crisis, offering counselling, connecting someone with family members, educating and giving information on specific psychological or neurologically based personal reactions, explaining behaviours of specific groups of people and sharing information on different forms of psychological help. Social interventions are supports that help people deal with the social part of their lives. These include any service that helps connect people as families, communities, neighbourhoods and other groups. Ideally, psychosocial interventions reflect cultural definitions and understanding of illness and well-being and include help and guidance required to deal with social structures such as education and health systems, official bureaucracies, legal and paralegal aid, housing and sanitation as well as learning about how to be mentally healthy in one's environment. Conversely, psychosocial mental health care does not include psychotherapeutic or psychiatric interventions.

Although various models of psychosocial care[f] exist, this article focuses on particular forms of group-based psychosocial counselling for women with mental health problems in Afghanistan.

Psychosocial counselling groups for Afghan women

It is difficult to assess the intensity or prevalence of psychological stress affecting various populations of Afghan women, for no regularized means have been developed for making such assessments directly. Intensity and prevalence have instead been chiefly inferred from the more easily observable level of stressful individual, social, economic, political and militarily generated changes wrought by thirty years of conflict and war. This being said, the Afghan women participating in these medica mondiale led psychosocial groups suffer primarily from a specific range of psychosomatic or behavioural symptoms. For example, some women have attempted suicide or performed acts of self-mutilation; others have chronic physical complaints or are anxious and depressed. The group participants report having experienced, and sometimes still experiencing, violent events caused by war and fighting or through individual acts of violence. The latter may be political or personal and is usually some form of domestic violence perpetrated by family members and husbands.

Psychosocial counselling may help such survivors better deal with the physical and psychological symptoms they developed after a traumatic event or a series of events has occurred. The literature shows the usefulness of psychosocial group interventions for individuals with particular mental health problems. It has been used to good effect in certain cultural settings[10] and is reported as being particularly helpful when working with women and children who have experienced

f) Broadly speaking these include psychological debriefing, psychological education, psychological screening and psychosocial counselling. Commonly used debriefing methods are either short forms of basic counselling interventions or Critical Incident Stress Debriefing (CISD). However, new studies suggest that CISD may not be very helpful for individuals who have experienced traumatic events and that this form of debriefing may instead reinforce fragments of these experiences as disturbing memories in the brain. (See[22,15] on a critical discussion about the usefulness of CISD.)

various forms of violence.[11-13] Psychosocial group counselling offers a treatment alternative to typical one-to-one counselling.[14]

Medica mondiale in Afghanistan has developed a particular counselling model called Basic Counselling Training (BCT)[g] that applies to working with individuals and with groups. The intent of the use of this model is not to diagnose or offer psychotherapeutic help. Instead, it emphasizes psychosocial interventions and empowerment strategies. The BCT model utilizes four key strategies that are integrated in the group counselling process: psycho-education to help women understand their reactions and behaviours, removal or relief from distressing symptoms, teaching of new social skills (for example problem solving skills) and development of new support networks with counselling group members.

Women joined these groups primarily as a result of hearing through word of mouth that this service was available in their districts. Sometimes her family members or a neighbour made the initial contact with the group counsellor. In other cases, local and international organizations, hospitals and "graduates" from the first round of groups made sure a woman in need met the counsellor assigned to her district. After an initial talk with the counsellor, women were asked to participate in one-to-one counselling sessions or in psychosocial counselling groups or else were referred to other services.[h]

In Afghanistan, whole communities were destroyed or fragmented through war and exile and it is useful to develop community based forms of healing beyond individual or family support.[15] The BCT model gives participants a chance to reconnect, to share and re-establish new community ties with other women.

Traditionally, Afghan women's contacts are limited to their immediate birth families and, once they are married, also to the women of their in-law families and their husbands. Depending on a woman's marriage arrangements[i] and on the level of acceptance by her new family, she will feel she is supported and develop a sense of trust. If she does not receive this support she may feel isolated and lonely and this sense of isolation is exasperated by her experiences of war and as a refugee or IDP. Particularly, widows suffer from social isolation and stigma and are economically dependent on their in-laws.[j] Many women may feel alone with her

g) The Basic Counselling Training Model was developed by S. Manneschmidt[23] and can be accessed through contacting K. Griese.

h) The first contact with the client usually entails a talk with the group counsellor. This is much more a talk than a typical clinical interview and takes place as much as possible in a private and confidential manner. At this stage, the counsellor decides with the woman if she wants to participate immediately in the counselling group or if she first attends individual sessions. If the woman needs help with medical or legal problems in addition to the psychosocial support, the counsellor will refer her to other services.

i) Important factors affecting a woman's status in her in-law family are the perceived influence and importance of her family of origin, the value attached to her bride price, the level of respect and authority between the two joining extended families, the acceptance of this particular marital union by bride and groom and the physical distance of the in-laws ~~residence~~ to the bride's family or community.

j) Many participants in the counselling groups are widows. Their material and economic situation is usually very bad and they depend on hand-outs from relatives, neighbours or international aid organizations. Many experience violence by their in-laws or outside their homes. The program benefits from a good cooperation with CARE another humanitarian organization – to support widows through food distribution and skills building programs.

problems and have often lost perspective of their situation. They feel overwhelmed by their problems, are mistrusting and often have lost empathy for others. Very similar emotions are typically stated by women who have experienced and are still experiencing domestic violence.[16,17]

The counselling program had the following objectives: to have group participants learn to break through their isolation, to support the women developing new ties and networks, to facilitate sharing experiences and feelings and to show how they can help each other to access resources and support systems. They also learn to listen to each other and by doing so eventually reach out to people outside their group. In Afghanistan where women have traditionally learned only to trust members of their birth families, where they often have no support and experience direct violence through their inlaws and husbands, building trust with women they are not related to is a huge step toward their own healing.

Research methodology

This evaluation focuses on 12 counselling groups with 137 participants meeting from January 2006 to May 2007 in five mm district centres of Kabul.[k] 109 women took part in an evaluation that was set up for each individual group at the end of the group sessions. While groups were active, participants met weekly for two to three hours. On average groups met for eight and a half months. Each group varied in size but was limited to a maximum number of 13 participants. As of December 2007, a total of approximately 350 women had participated in the counselling groups but this assessment focuses only on the evaluations conducted with the groups mentioned above.

For the purpose of this study, the evaluation took place after group participants and its counsellors had decided to end the group meetings with which a given individual was involved. The evaluation was done in a group setting with all participants present. Each participant was asked to answer a standardized set of four open-ended questions. The questions were formulated to be as simple as possible and were intended to find out for what reasons the women joined the groups, what they had learned in the groups, if changes had occurred in their lives since they joined the groups and what they wanted to do after leaving the groups.

Each evaluation took approximately two hours. The evaluation took place in the groups' meeting places in the district centres and was conducted by a PSP team member[l] in the absence of the groups' counsellors. The first round of evaluations was conducted by the PSP international program manager with the help of the national PSP coordinator who translated. After receiving training on conducting the evaluation, this staff member took over the task to evaluate the groups and followed the same standardized evaluation procedure.

The information given by the participants was immediately recorded in English

k) Group participants ranged from 16 years to over 60 years of age. There were some older women but they did not know their age and could not give reference points to the year they were born in. The majority of the women were illiterate and only a small number (approximately 5% of all participants) had some form of formal education. Many women were widowed and had no employment.

l) PSP stands for Psychosocial Program and is one of departments of medica mondiale in Afghanistan.

on evaluation forms during the evaluating process. Later this information was tabulated, coded and eventually put into themes to be analyzed. This was done by us at medica mondiale's headquarter office in Cologne, Germany.

It is important to mention that medica mondiale's group counselling interventions did not usually take place promptly after a woman's exposure to a traumatic event. Rather, the event or events in question typically had taken place many years previously, and typically also, no help was given at the time. When such women joined a medica mondiale group they were then usually suffering from disabling or incapacitating symptoms. Therefore, the assumption can be made that these women's initial reactions to what had happened to them exceeded their ability to cope with the event in a manner that they or their families regarded as normal reactions. They were not able to reconstitute or heal spontaneously or in a sufficient manner using available resources and supports. Although some of the participants suffered from serious mental health problems, the group counselling interventions avoided the use of diagnostic criteria and concentrated on specific and directive techniques grounded in behavioural-cognitive and socially oriented approaches.[m]

m) According to Salomon[24] psychosocial interventions are directed to prevent long-term consequences in victims who display early symptoms of stress and/or behavioural dysfunction following exposure to a traumatic event. Potential interventions include participation in self-help groups for individuals with common problems. These interventions do not include formal treatment procedures for PTSD such as behavioural flooding techniques or pharmaco-therapy.

Summary of participants' responses

The first question asked was about the purpose of the group. The majority of answers focused on the hope of finding relief of physical and psychological symptoms. 28.5% of answers mentioned general or specific pain, trembling, feeling paralyzed, shortness of breath and numbness. Another 24.1% of answers described frustration, depression, nervousness, being extremely worried, anxiety, aggression, self-mutilation and fear of going "crazy".

Other answers mentioned the importance of sharing feelings and thoughts (15.8%) and the need to discuss family problems and conflicts in a safe environment

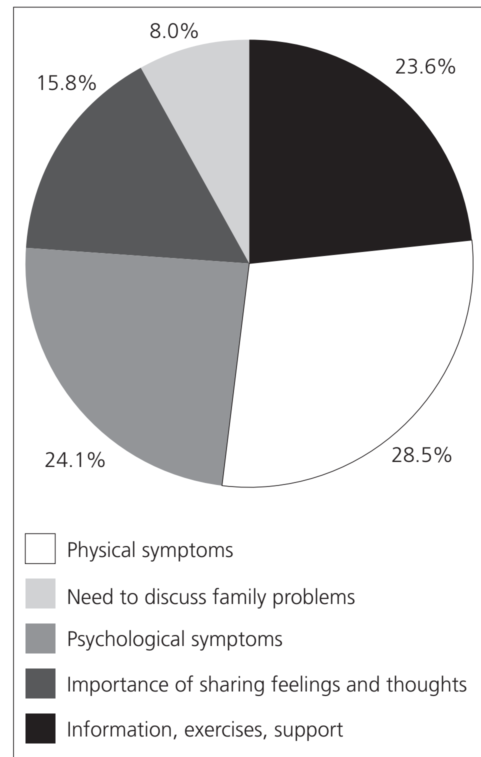

Figure 1. *Can you describe the purpose of the group?*

(8%). Fewer answers were about the participants' wish to receive information on mental health, to learn specific exercises and to receive social support (23.6%) (Figure 1).

The second question asked the participants to say what they learned in the groups. 46% of the answers focused on the learning of social skills related to improved communication and changes in mood and behaviour. 27% of the answers described new problem solving skills and another 27% of the answers mentioned the exercises they learned in the group sessions (Figure 2).

The third question asked if anything changed in the life of the participants since they joined the groups. More than half of all answers (55%) described the positive effects on their social life. Some participants mention that the interactions with their family members have become better; others mention that they have learned to deal better with stress, make decisions more easily and feel less shy. 35.7% of answers focussed on the improvement of participants' general health. They say their mood has changed and they are happier and they experienced a reduction or disappearance of some of their problems. However, 3.3% of the answers indicated that these women had not solved any of their problems (Figure 3).

The fourth and last question asked about the steps the participants wanted to take in

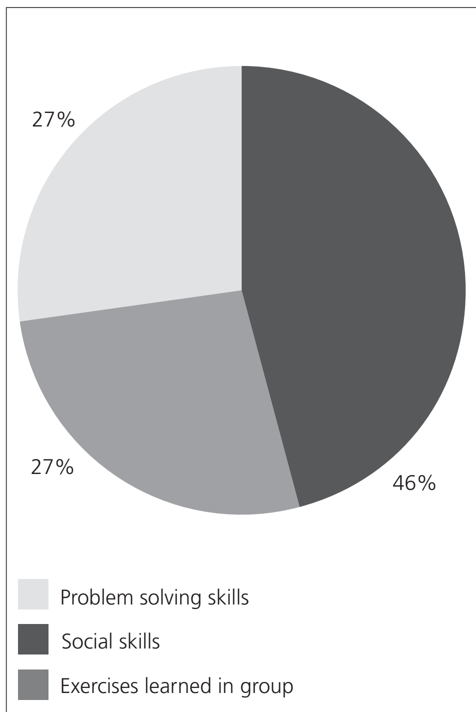

Figure 2. *Can you describe what you learned in the group?*

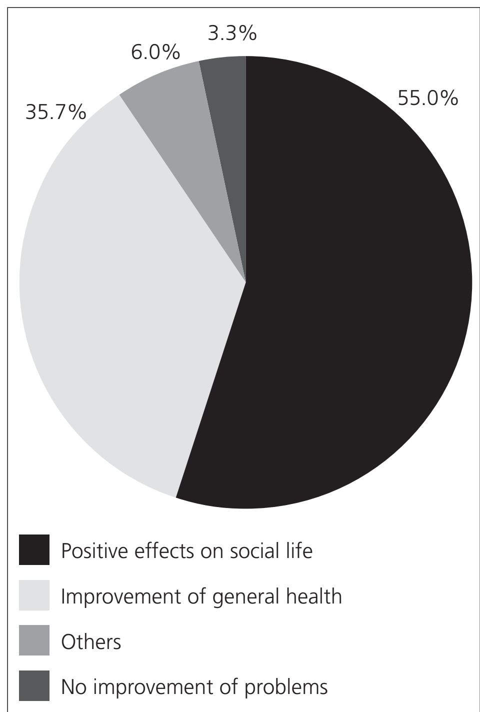

Figure 3. *Did anything change in your life since you joined the group?*

the future to make their lives better. Half of the answers (50.9%) related to the women's wishes to find employment. Many wanted to find work together with the other group members. 30% of answers mentioned the importance of taking care of one's own well-being. Possibly, some said this because they wanted to keep on sharing feelings with a friend and others mentioned they are now coping better with stress. A smaller number of answers described the wish to take care of others in a better way (9.1%) and a minority said that they wanted a formal education (3.6%). 2.8% of answers reflected that the participants had no future plans and 3.6%

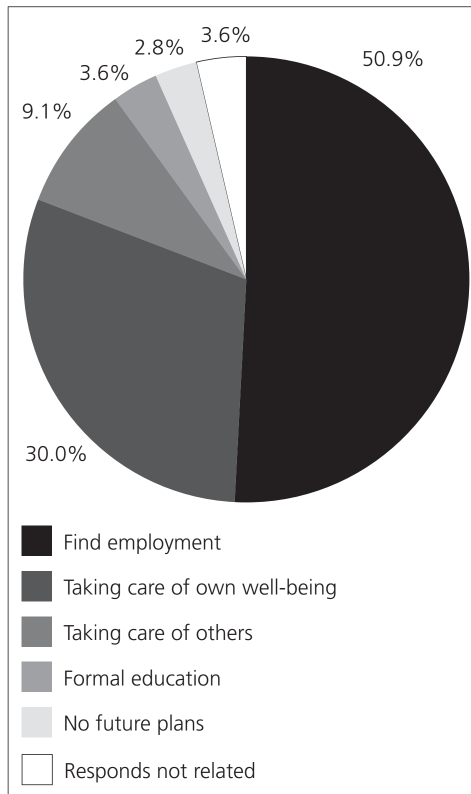

Figure 4. *What steps do you want to take in the future to make your life better?*

responses did not relate to the question asked (Figure 4).

The evaluation outcomes clearly present the benefits the women felt they gained from being in the counselling groups. The women reported improvement of somatic and emotional complaints. Some women described physical dysfunction and actual injury caused by the violence they had experienced. Others expressed their suffering in somatic terms focusing on specific pain or generalized aches. In Afghan culture physical complaints are an acceptable way for women to express suffering and sometimes this is strategically used to allow for time away or to negotiate certain rights or benefits.

Additionally, women improved their social skills which they related to being connected with others who listened and supported them. This development of a sense of belonging led to strong group cohesion. In the context of Afghanistan, this is a remarkable achievement as women are usually taught not to trust other women outside of kin affiliations. And as many have also experienced violence and abuse through inlaw family members it is especially astounding that the participants established a high level of trust and solidarity with each other.

Conclusion

The evaluation of a particular model of psychosocial group counselling proved to be useful and relevant for participants, Afghan women who had experienced forms of war-related and domestic violence. The group process presents a different approach regarding the possibility and validity of group evaluations. It followed a threefold strategy: 1) to give information about mental health and explain particular physical and psychological symptoms in relation to mental health problems, 2) to teach specific techniques to

achieve relief or removal of distressing or disabling symptoms and 3) to help establish support and friendship ties among group members.

The women learned in the group to express and verbalize their complaints and ways to share their problems with others in an appropriate manner. The group process emphasized listening skills and giving each participant a chance to speak. The format of the group sessions was ritualized and it was repeated in the same manner in each group session. This taught the women to be patient and to take time to listen to other's problems. They were able to give their opinions and share their experiences and these were validated. This process was a new experience for most participants, particularly those whose lives are marginalized due to widowhood, poverty, lack of education and victimization through domestic violence.

The participants were taught specific techniques on how to deal with their complaints and problems through physical or psychological exercises. These proved to be extremely helpful to relieve stress and pain. Learning and practicing these exercises gave the participants newly acquired expert ise and many used this new knowledge to teach their children or other neighbourhood women. Thus, the group process became a tool of empowerment that built on group interaction and support of peers rather than staying focused on counsellor-client interaction. It emphasized group strength rather than individual learning. After the termination of the groups, participants still wanted to meet and decided to start with a literacy program that allows them to continue being together in their groups and, additionally, teaches them new skills.

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