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Article

Feasibility and efficacy of a peer-led recovery group program for war-related trauma in Libya

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Abstract

After 42 years under the brutal rule of Colonel Muammar al-Gaddafi, the people of Libya rose up on 17 February 2011 and demanded change. The 9-month civil war that followed resulted in the deaths of approximately 15,000 Libyans. This study reports on the feasibility and efficacy of a 10-week peer-led group-based recovery intervention for war-related trauma implemented at the Garyounis internally displaced person camp outside of the city of Benghazi. The results of this preliminary assessment show that the use of peers to lead recovery groups for war-related trauma is not only feasible but also appears to be highly efficacious in reducing posttraumatic stress disorder symptoms in civilians. The reported subjective experiences of those involved in facilitating the groups suggest that the use of peers, rather than mental health professionals, is a realistic option to minimize the long-term effects of war-related trauma.

Keywords

Civilians, groups, posttraumatic stress disorder, war-related trauma

After 42 years under the brutal rule of Colonel Muammar al-Gaddafi, the people of Libya rose up on 17 February 2011 and demanded change. The first peaceful protests began in the eastern city of Benghazi, but quickly spread across the country. The government attempted to quell the protests with force, pushing the country into civil war. Although opposition forces, with the help of North Atlantic Treaty Organization (NATO) air strikes, did eventually achieve their goal of removing

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Gaddafi from power, the human cost was significant. Although precise data are not available, the new Libyan government estimates that as many as 15,000 were killed and 50,000 injured during the 9 months of fighting (Black, 2013).

Armed conflicts, such as the Libyan revolution, often set the stage for a stressful and protracted postwar period (Layne et al., 2001). Thousands of Libyans presently live as internally displaced persons (IDPs) in camps within the country. Many more experience problems associated with widespread poverty and unemployment, inadequate living conditions, inadequate health care, and disruptions within their families and communities.

The psychosocial effects of war and its aftermath on civilian populations have been documented in a variety of geographic regions and cultural settings, including the former Yugoslavia, Palestine, Iraq, Cambodia, and Uganda (De Jong, Komproe, & Van Ommeren, 2003; Goldstein, Wampler, & Wise, 1997; Johnson & Thompson, 2008). Collectively, these studies demonstrate that civilians living in conflict zones are often exposed to high-magnitude, war-related trauma placing them at an increased risk of posttraumatic stress disorder (PTSD), depression, somatic complaints, disturbances in family and peer relationships, substance abuse, and a variety of other adverse outcomes which the country's mental health system (if it exists) is often unable to effectively manage.

A substantial body of research has demonstrated the effectiveness of several treatments for PTSD. These treatments include cognitive behavioral therapy, eye movement desensitization reprocessing, prolonged exposure, and stress inoculation therapy (Foa, Gillihan, & Bryant, 2013; Haugen, Evces, & Weiss, 2012). In addition, a number of pharmacological interventions have also been shown to be efficacious, including selective-serotonin reuptake inhibitors, serotonin norepinephrine reuptake inhibitors, and atypical antipsychotics (Alexander, 2012; Ipser & Stein, 2012). It has been suggested that psychotherapy in combination with pharmacotherapy may be the best treatment approach for effective recovery from PTSD. Unfortunately, all of these standard, empirically validated treatments for PTSD require a system of highly trained mental health professionals to be in place and accessible to the distressed individual; as mentioned above, this is rarely the case in areas impacted by military combat.

In October 2011, a team from Acts of Mercy International (AMI; a Christian relief and development organization) entered Libya to assess mental health needs in relation to the ongoing armed conflict. They found a highly traumatized civilian population adversely affected by both the ongoing civil war and years of oppression under a tyrannical regime (i.e., systematic rape, political imprisonment, and torture). They also found that the limited mental health system which existed was inadequate to deal with the significant psychiatric and psychological problems that were being presented.

In response, a 10-week peer-led group recovery curriculum for war-related trauma was developed and implemented in eastern Libya (Fitzgerald, Elkaied, & Weissbecker, 2012). Within the country of Libya there are less than 30 psychiatrists and no licensed psychologists or social workers, so reliance on mental health–care providers to facilitate groups was not possible (Charlson et al., 2012). However, there is strong evidence for the efficacy of peer involvement across the spectrum of mental health services, from case management to workshops to leading groups.

Addressing mental health issues in peer groups multiplies possible leaders, serves many people at once, and includes the many powerful benefits of group treatment, such as social support and universality. Peer-led groups come in several forms. Mutual help groups aim to provide social support by sharing struggles and emphasize meeting topics chosen by those who attend, as opposed to a structured curriculum (Pistrang, Barker, & Humphreys, 2008). Other supportive groups have peer leaders who provide a structure and sequence to the interactions of members. These groups provide a middle ground where leaders are clearly identified, but the structure of the group is less

formal. In contrast, peer-run courses usually involve a structured, time-limited set of topics that are taught by someone who has experienced the course as a consumer. The Hope Group curriculum used in this study would fall into this category. Each of these types of peer-led groups has evidence supporting their effectiveness.

Mutual help groups such as Alcoholics Anonymous have a long history in the treatment of alcohol use disorders and play a major role in addressing the burden of care in that area. Kelly and Yeterian (2011) reviewed evidence for the effectiveness of these groups and found that mutual help groups generally performed as well or better than professional intervention but had significantly lower treatment cost per individual. Considering a broader spectrum of mental health issues, a recent review concluded that initial evidence indicated that outcomes for mutual help groups were comparable to much more costly professional treatments (Pistrang et al., 2008).

Group interventions also appear especially popular as part of the treatment of serious mental illnesses like schizophrenia and bipolar disorder. Several examples of widely implemented peer-led programs have been documented. Building Recovery of Individual Dreams and Goals (BRIDGES; Pickett et al., 2010) "is an 8-week peer-led course designed to empower adults with psychiatric disabilities by providing them with basic education about the etiology and treatment of mental illness, self-help skills, and recovery principles" (p. 97). Social support and the real-life recovery example of peer leaders are seen as central to fostering hope. A randomized controlled trial of this intervention showed significant improvements in recovery among participants (Cook et al., 2011).

Several programs have been developed that combine some form of manualized self-help and a peer-led group setting. Wellness Recovery Action Planning (WRAP; Cook et al., 2010) is a peer-led self-management intervention intended to help individuals manage long-term illnesses whether or not they receive formal services. Delivered over eight sessions, leaders emphasize holistic health, wellness, strengths, and social support, often while sharing illustrations from their own lives. A number of studies have examined the effectiveness of WRAP, with all reporting increased markers of recovery as a result of participation (Cook et al., 2012; Fukui et al., 2011).

In Pathways to Recovery (Fukui, Davidson, Holter, & Rapp, 2010), peers guide individuals through a specific workbook over 12 weeks to help them

> develop a personalized recovery plan wherein they explore their lives and set goals across nine domains of life that include (1) home, (2) learning, (3) assets, (4) meaningful work, (5) leisure and recreation, (6) health and wellness, (7) intimacy and sexuality, (8) spirituality, and (9) social support. (p. 43)

A similar 12-week group organized around the Recovery Workbook has also demonstrated significant improvement in recovery for participants (Barbic, Krupa, & Armstrong, 2009).

In a recent editorial for *Psychiatric Rehabilitation Journal*, Judith Cook (2011) described several review articles and recent randomized controlled trials which demonstrated that peer-delivered services had at least equivalent effectiveness to non-peer-delivered services, and in many cases were accompanied by additional benefits. She noted that the evidence is especially strong when peers deliver well-defined services, and concluded that current evidence is strong enough that the question is not whether to fund peer-delivered services, but how.

Clearly, there are many voices supporting the efficacy of peer-delivered mental health services and their value in addressing the large burden of care for mental illness in areas that lack the necessary resources. However, the use of peer-led groups for war-related trauma in civilian populations has not been investigated. The following study reports preliminary data on the feasibility and efficacy of a peer-led recovery group intervention for individuals exposed to war-related trauma in Libya.

Method

Participants

AMI's trauma-related relief efforts have focused on the Garyounis IDP camp outside the eastern Libyan city of Benghazi. The camp houses approximately 2500 IDPs from the town of Tawergha. Tawergha was destroyed during the recent civil war, and subsequent to the end of the conflict, the Tawerghan people have been persecuted and abused for their past connections to the Gaddafi regime (Mzioudet, 2013). In November 2011, individuals from the camp were recruited to be trained as trauma recovery group facilitators. A total of 10 individuals (6 men, 4 women; mean age 39.6 [13.0] years) volunteered to be trained. All volunteers completed a single 4-hr training session led by AMI staff and translated into Arabic. The training included both lecture and experiential/role playing exercises related to leading groups. A local mental health–care provider was asked to serve as a contact for the group facilitators if they had questions or needed to refer group participants for additional treatment. This individual came to the camp approximately once a month to meet with the group facilitators.

Instruments

Hope Group participants were asked to anonymously complete an Arabic translation of the civilian version of the PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) during the first and last sessions of the Hope Group. The PCL is a 17-item, self-report measure based on the *Diagnostic and Statistical Manual of Mental Disorders–Fourth Edition, Text Revision* (*DSM-IV-TR*; APA, 2000) criteria for PTSD. Internal consistency for the English translation has been reported to range from 0.73 to 0.94 with good test–retest reliability (Conybeare, Behar, Solomon, Newman, & Borkovec, 2012; Keen, Kutter, Niles, & Krinsley, 2008). Participants were asked to indicate how much they were bothered by PTSD symptoms over the past month using a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*extremely*). Symptom severity scores on the scale range from 17 to 85. A PCL total score of greater than or equal to 50 predicts a clinical diagnosis of PTSD (as assessed by the Structured Clinical Interview for *DSM-IV*; First, Spitzer, Gibbon, & Williams, 1997). In March 2011, an assessment team from AMI UK returned to the camp to collect the checklists and interview the facilitators concerning their experiences in leading the Hope Groups. This research was approved by the Baylor University Committee for the Protection of Human Subjects in Research.

Procedure

The Hope Group curriculum is a 10-week cognitive behavioral therapy–based group recovery intervention for war-related trauma designed to be facilitated by peers (Stanford & Padilla, 2011). The curriculum focuses (Table 1) on four main areas related to trauma recovery: psychoeducation (10%), relationship and support building (20%), emotional expression and regulation (30%), and cognitive skills development (40%). Supplemental sessions are also included for victims of sexual assault (Rape and Sexual Assault) and military combatants (Combat Exposure). Each week's material is laid out in a simple-to-follow common format: FACTS, specific facts related to the week's topic to be used for discussion, and FUTURE, practical suggestions and tips that participants can immediately apply in their daily lives. Each session is expected to last 1.5 to 2 hr. A Libyan teacher at an English training school in Benghazi was hired by AMI to translate the Hope Group curriculum into Libyan Arabic. One of the curriculum authors (J.I.P.) has over 10 years of experience

Table 1. Hope Group weekly topics.

Week 1: Stress and Trauma—Traumatic experiences are sudden and unexpected events, outside the range of normal human experiences, that threaten life, health, and/or personal integrity of a person or others, and to which the person responds with intense fear, horror, or helplessness. Normal stress-related reactions to trauma, many of which normalize with time, are fear and anxiety, the avoidance of reminders, fantasies and dreams, recollections of the event, sadness and anger, guilt and self-blame, and concentration and sleep problems.

Week 2: Safety, Predictability, and Control—All individuals need three crucial elements in their lives to feel supported and begin to recover after a trauma. These elements are safety, predictability, and control. In helping survivors cope with the aftermath of disaster, efforts should be made at all opportunities to promote any and all of these three basic needs.

Week 3: Rest, Relaxation, and Joy—Individuals may not be able to directly influence the main causes for their stress following a trauma, but they can always protect and strengthen themselves through what is within their control. For example, a simple daily structure and routine can bring a sense of peace and rest, while using relaxation techniques can help minimize the harmful effects of stress. Making rest, relaxation, and joy a regular part of life happens through structure, hobbies, and humor.

Week 4: Positive versus Negative Coping—Everyone has natural ways of coping with trauma and stress. Some coping strategies are positive and healing, while others are negative and adversely affect the person trying to recover. When trauma survivors take direct positive action to cope with their stress reactions, they put themselves in a position of power. Active positive coping with the trauma makes you feel less helpless.

Week 5: Depression—Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. True clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or longer. A depressed mood that occurs in reaction to trauma is often referred to as a reactive depression.

Week 6: Friends and Family—Survivors of trauma often experience problems in their intimate and family relationships or close friendships. Posttraumatic stress involves symptoms that interfere with trust, emotional closeness, communication, responsible assertiveness, and effective problem solving.

Week 7: Crisis and Problem Solving—The problems and difficulties associated with living after a disaster are literally overwhelming. Prioritize the problems and issues you are dealing with; take them one at a time, beginning with the one that you have the most control over. Seek input from others on how to prioritize and best respond. Crisis and immediate safety concerns for you or your loved ones should always be dealt with first.

Week 8: Grieving and Loss—A common consequence of war is the death of close friends and/or relatives. Personal loss can bring profound sadness into our lives as we grieve our loved one's passing, the life we had with them, and our expectations for the future that will not be realized. It is important to remember that grieving is a normal process that takes time. A supportive community can bring great comfort during this time.

Week 9: Guilt and Shame—People who survive war often feel guilty or shamed. Some feel guilt for having survived when others did not, while others feel they have failed their friends and families by not being able to overcome the devastating consequences that follow such events (e.g., homelessness, unemployment, physical, and psychological injury). The consequences of war are overwhelming events that no one is ever fully prepared to handle. The events you have survived and the consequences you are presently dealing with are in no way your fault, and you should not hold yourself responsible for them.

Week 10: Staying Resilient—Resilience is the capacity to do well when faced with difficult circumstances, by protecting one's personal integrity under pressure and maintaining a positive outlook on life. The following factors play a role in building resilience in individuals and families: empathy, care, acceptance, respect, and support in close relationships, social responsibility, gaining knowledge and developing life skills, solving problems successfully, and resilient role models.

(Continued)

Table 1. (Continued)

Supplemental sessions
Rape and Sexual Assault—When someone has been raped or sexually assaulted, they need a great deal of support from the people around them. Many people simply do not know how to help somebody through the trauma of rape or sexual assault, and so they become frustrated and bewildered and feel that they are in some way failing the person they care about. These feelings can sometimes be transmitted to that person, making it even harder for them to cope with their experiences and often leaving them with even more feelings of guilt and confusion.
Combat Exposure—Combat experiences are the most significant factors that put soldiers at risk for psychiatric symptoms or lasting mental health problems. Combat exposure that particularly leads to stress symptomatology includes exposure to death and dead (which includes handling dead bodies, knowing someone who was killed, witnessing death, or disfigurement of allies or enemies), being wounded or injured, witnessing suffering, being at risk of being killed or wounded, and/or participating in killing or wounding others.

living and working in Arabic-speaking Muslim countries and edited the material for cultural appropriateness in cooperation with the translator.

Results

Group facilitator interviews

Between November 2011 and March 2012, the 10 Hope Group facilitators successfully led 17 groups in the IDP camp with 149 participants. Group sizes ranged from 3 to 15 participants with an average group size of 8. All 10 group facilitators reported that the groups were helpful to those involved, that they would be willing to facilitate a group again, that they recruited group participants from their friends and relatives in the camp, that they met regularly with the other group facilitators for support and guidance, that they interacted with the group participants about the topics discussed outside of the group setting, and that they were personally impacted in a positive way by facilitating the group. Eight of the 10 facilitators reported that they felt they could successfully train another person to lead a Hope Group.

Group facilitators rated the cognitive skills development sessions as the easiest to lead, while the emotional expression and regulation sessions were rated as the most difficult to lead due to their heavy emotional content (e.g., grieving and loss). When asked what they would most like to change about the Hope Groups, the facilitators suggested more time for each session (meeting more than once on a given topic) and that the group last longer than 10 weeks.

PCL

Due to logistical problems, PCL data were only available from two of the groups. A total of 19 Hope Group participants (10 men, 9 women; mean age 30.3 [13.2] years) completed the scale at the beginning of the group, while 9 completed it again at the end. The average PCL symptom severity score for the 19 participants before beginning the group was 46.0 (13.4), while the average symptom severity score for the nine participants upon completion of the group was 28.3 (10.8), $t(26) = 3.45$, $p < 0.01$. Of the 19 participants assessed before beginning the group, 11 (58%) met criteria for the diagnosis of PTSD, while none of the nine participants assessed after completing the group met criteria for PTSD, $\chi^2(1) = 8.58$, $p < 0.01$.

Discussion

The results of this preliminary assessment suggest that the use of peers to lead recovery groups is not only feasible but appears to be highly efficacious in reducing PTSD symptoms in civilians exposed to war-related trauma. Like any new endeavor, this intervention experience contained both successes and failures.

In reviewing our response in Libya, we found that the following were important factors in our success: (1) focusing on existing institutions, groups, and organizations to host and run the Hope Groups; (2) building relationships with leaders in groups with the highest exposure to war-related trauma (e.g., IDP camps, brigades, and militias); (3) conducting a community-based mental health initiative while building relationships with local mental health professionals and institutions at the same time—this link is particularly important because having local professionals involved in the program increases the potential for longevity, support, and oversight beyond the time the nongovernmental organization (NGO) is present; and (4) using an easily reproducible, manualized program allowing multiple leaders to be easily trained in a short period of time.

While the intervention as a whole was successful, a number of mistakes and miscalculations limited its overall impact. First, we underestimated the need for, and our ability to provide, support for the leaders we trained. This meant that the only location that we were really able to give continued support at a sufficient level was in the IDP camp. In other locations, we were unable to offer the ideal level of support due to transportation and language limitations. Thus, a number of those trained to be leaders did not feel supported enough to actually start a group. This also meant that we failed to fully track the number of groups being run outside the IDP camp as we did not have enough people who spoke the local language to follow up all those trained across the region. It would be beneficial to develop plans for the management and tracking of groups prior to responding and to have staff who speak the local language to offer ongoing support to the group leaders.

Second, while the content of the program was designed for nonprofessionals, it was very challenging for translators unfamiliar with mental health concepts and topics. We found that a number of translators we worked with struggled to explain the nuances of the content effectively, and this limited the understanding of those trained. A very high level of English and some knowledge of mental health concepts are required to effectively translate the material both verbally and in writing.

Third, the Libyans we had trained to be able to train others on the Hope Group material were only successful in the IDP camp, and this indicated the need for further support to empower those trained to train. Finally, due to the present form of the materials, the groups were very reliant on paper and local printing resources. It would be good to look at developing production alternatives so that this is not a restriction on new groups in some locations. Could a smaller booklet be made that could be brought in? What do we do for populations where many are illiterate?

The greatest potential for this type of program appears to be in enclosed communities with shared traumatic experiences such as IDP/refugee camps, army brigades, and/or militia groups. Given the small number of respondents and lack of a control group, the results should be interpreted with some caution. However, the reported subjective experiences of those involved in facilitating the groups suggest that the use of peers, rather than mental health professionals, is a realistic option to minimize the long-term effects of war-related trauma. It is hoped that the continued development of the Hope Group curriculum will result in a simple and inexpensive method for relief agencies and governments to effectively respond to war-related trauma in civilian populations within weeks of a conflict.

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