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Complex Emergencies and the Tree of Life: A community-based approach to dealing with trauma.

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Background

Whilst there is continual reference to the suffering of those affected by the Zimbabwe crisis, particularly in reference to *Operation Murambatsvina* and the burgeoning food crisis, insufficient attention has been given to the mental health consequences, both psychological and social, of the massive social upheaval and organized violence and torture that has accompanied the crisis.

A strong argument can be made that Zimbabwe now conforms to the kind of situation currently termed a "complex emergency". In the context of economic collapse, the collapse of all supportive services [health and social welfare], severe food shortages, and mass violence, Zimbabwe resembles a country at war, but in the absence of the more obvious features of war.

A complex emergency requires a strong and sustained humanitarian response and here the mental health needs of those affected in the current crisis should be addressed, and any programme should adopt as a framework the following principles (Mollica et al. 2004; Mollica, Guerra, et al.2004):

- *The co-ordination of mental health care;*
- *Good basic assessment of the problems and the establishment of a monitoring process;*
- *Implementation of an early intervention phase;*
- *Utilising of the de-facto mental health system;*
- *Emphasis on training and education;*
- *Implementing, managing, and monitoring a culturally competent system of care;*
- *Stress on ethics and community participation;*
- *Care to prevent negative mental health consequences in mental health providers;*
- *Commitment to outcome assessment and research.*

These principles are commonly recognised by various expert groups as the basic framework for providing effective mental health care in complex emergencies (IASC.2007), and should be applied in Zimbabwe in the development of a national programme for addressing the mental health needs of the Zimbabwe population affected by both the current crisis as well as the earlier periods of trauma.

There are now a number of excellent reports on the crisis facing Zimbabwe, so it is of great concern that virtually a none have concerned themselves with the mental health dimension of the crisis. Whilst it must be acknowledged that food, shelter, and medical care are always priorities in emergencies, it is also the case that the mental health needs in emergencies are often overlooked. It is for this reason exactly that the UN and other expert groups have made a decided effort to keep the mental health agenda firmly in the

strategies developed for internally and externally displaced populations. This be no less the case for Zimbabwe in its complex emergency.

Trauma and complex emergencies

The term "complex emergency" is increasingly being used to describe situations of disaster, frequently political in origin and process, which result in the massive destabilization of a state's capacity to care for its citizens (WHO.2003). As Richard Mollica and his associates have put this, *A complex emergency is a social catastrophe marked by the destruction of the affected population*'s *political, economic, socio-cultural, and health care infrastructures* (Mollica et al. 2004): no better description could characterize Zimbabwe today.

Now complex emergencies can quite clearly occur as a consequence of natural events, as in the recent Asian tsunami or the effects of Hurricane Katrina on New Orleans, but they can also occur as a consequence of human intervention, as in periods of civil war or low intensity conflict, or what may be termed "organized violence and torture". In this latter case, there may well be destruction of political and economic structures, but here are also frequently the effects of the direct actions of humans on other humans, and no countries in Africa have made this more evident than the Democratic Republic of the Congo, Rwanda, or Sudan. A distinction should therefore be made between accidental harm causing trauma, as in natural disasters, and deliberate infliction of harm as is seen in wars, civil wars, low intensity conflict, genocide, and widespread political repression.

This report is not concerned with describing the many ways in which trauma may be inflicted during complex emergencies, but rather to very briefly describe their effects. The most obvious effects are physical, seen in illnesses and injuries, which may be short-lived, but also may lead to long-term disability. However, the most persistent consequences will be psychological, and especially if the trauma was deliberately inflicted (Mollica et al. 2004). Here four points should be emphasized:

- *Firstly*, the most probable long-term consequence of experiencing a traumatic event is the development of a psychological disorder;
- *Secondly*, the probability of psychological disorder following a traumatic event increases with the frequency of experiencing physical harm, such as torture;
- *Thirdly*, the probability of psychological disorder increases with the number of exposures to trauma such as organised violence or torture [OVT];
- *Fourthly*, whilst men are probably the most common primary victims of OVT, women and children are disproportionately the most common secondary victims, and certainly secondary victims are much more common than primary victims.

The comment should also be made that it is well-established that psychological disorder due to violence can be caused by physical injury or torture, but equally that mere psychological exposure, as in witnessing violence, or even living in situations of very common physical violence, such as a war or low intensity conflict, can also cause psychological disorder.

Whilst there are very few good epidemiological studies of the incidence or prevalence of disorders due to trauma in Zimbabwe, there are a number of studies that are helpful in understanding the likely picture.

These studies suggest that there are a number of periods in which trauma has occurred as a result of mass violence. This has occurred against the background of already existing mental health problems, most usually termed "common mental disorders" [CMD].

The general mental health picture that obtains in Zimbabwe indicates that CMD have been increasing in Zimbabwe over the past three decades. These are summarised in Table 1 below.

The first epidemiological studies indicated a picture that largely similar to that obtaining in western countries as well as in African countries, with prevalence rates of roughly between 20 to 30%. Some rates were higher, but generally the pattern was similar to that seen in most of Africa (Reeler.1991). However, it appears that the rates have shifter upwards in a dramatic fashion in recent years, as seen in a recent unpublished community survey in Harare, which showed a prevalence rate of nearly 40%. There was also a marked shift in the risk factors associated with CMD, with experience of violence increasing risk significantly, and most startling the association with having goods confiscated, which increased the risk by 14 times. Thus, it would appear that not only has the deteriorating socio-economic environment had a deleterious effect on the mental health of Zimbabweans, but also that the increased levels of violence have been having an effect.

Table 1
Zimbabwean studies of the prevalence of disorders due to Trauma

Study	**Sample**	**Instrument**	**Prevalence**
Amani Trust [1997]	Community survivors	SRQ-20	13%
Human Rights Forum [1998]	Food riots victims	SRQ-8	36%
Idasa [2006]	Zimbabwe refugees in South Africa [street survey]	SRQ-8	47%
SACST [2008]	Zimbabwe refugees in South Africa [multiple sites]	SRQ-8	49.50%
Reeler et al [1998]	Primary care clinics	SRQ-20	51%
WOZA women [2007]	WOZA members	HTQ	53%
Action Aid International [2005]	Victims of Operation Murambatsvina	SRQ-8	69%
CSVR [2007]	Women refugees in South Africa [clinic attendees]	SRQ-8	71%
Reeler& Mupinda	War veterans	SRQ-20	73%
Amani Trust [2002]	Commercial farm workers	SRQ-8	81%

Psycho-social support for victims of organized violence and torture

Recent expert opinion has made clear statements about what should take place in states of complex emergencies (Mollica et al. 2004):

> *Early mental health interventions should focus on supporting public health activities aimed at reducing mortality and morbidity; offering psychological first aid, identifying and triaging seriously ill patients who need specialised psychiatric care, and mobilizing community-based resiliency and adaptation to the new circumstances affecting people during the emergency.*

Furthermore, comprehensive guidelines for the mental health and psychosocial support have been developed in recent years by the Inter-Agency Standing Committee [IASC], and a variety of different mental health and psychosocial interventions can be applied within these guidelines (IASC.2007; Intervention. 2009). Whether dealing with mental health, psychosocial support, or HIV/AIDS, there are a set of common principles that need to be applied, as was stated earlier [see above].

It is evident that no treatment can be efficacious if the correct diagnosis is not found, and here it is extremely important to note the very low rates of detection by health workers. Detection of psychological disorders is generally very poor, even amongst doctors, and the survivors of torture are no exception to this finding. The remedy for poor detection is training of health workers in detection skills, and, as in Zimbabwe has shown, training can be easily done, and can have immediate benefits (Reeler & Mbape.1998; Amani.2000).

Disorders due to OVT present special difficulties in assessment for health workers, and will thus require the combined efforts of a team rather than single worker. The current state of the medical services and the enormous morbidity due to violence may preclude the development of a specialist service for this client group, but a minimum service can be developed, most usefully around the role of the nurse. Examples of using nurses are available both in Zimbabwe and South Africa (Amani.2000).

Treatment must be holistic, dealing with the physical, the psychological, and the social. Treatment should stress equally the individual, the family and the community, and thus will require a team approach. The principles of primary health care - cure, rehabilitation, prevention and promotion - should always guide the organisation of services for survivors of OVT. This requires the recognition that the point of health care be close to patients' homes, and that the staff of these health facilities be able to manage the conditions that present to them. Experience in Zimbabwe suggests that services can be organised to provide effective detection and referral from the periphery, providing there is the appropriate training of staff.

However, in situations where there is paucity of trained personnel, it is critical, as stressed in most expert opinions, to utilize the skills available in the community. Not only to employ these skills because of pragmatic considerations, but to make a determined effort to use the available skills in order to strengthen the community: the front line for care must be the community, supported by professionals at the nearest level to the community. Here the primary care history and experience in Zimbabwe will be crucial and provides already a wealth of experience that can be employed in line with the IASC Guidelines.

Developing a community response to trauma: The Tree of Life

Although it will be imperative for the capacity of the state health services to be improved, this will obviously be a long-term process, and there is need for an immediate response. This can only be effected by using the existing resources within the communities such as they may be. As pointed out by Mollica et al, this needs to follow what is termed the "psychosocial" approach:

The psychosocial approach suggests that although people are affected in many ways, three areas in particular are affected: human capacity (ie, skills, knowledge, and capabilities), social ecology (social connectedness and networks), and culture and values. People need support to enhance both their own and the community's psychosocial well being by strengthening each of these areas.

There are a number of approaches that can be utilised here that have already shown some efficacy with older populations of survivors. One approach that shows considerable promise, and already has a fair track record is termed the "Tree of Life". The Tree of Life was originally developed as an approach for assisting unemployed youth. It was adapted to the needs of Zimbabwean political violence victims living in exile in South Africa in 2002. This process was introduced to trauma survivors in Zimbabwe in 2004 as an attempt to address the psycho-social difficulties faced by survivors in Zimbabwe, most of whom still lived under threat and were displaced.

The Tree of Life is a healing and empowerment workshop that combines the concepts of story-telling, healing of the spirit, reconnecting with the body and re-establishing a sense of self-esteem and community. This process was developed from traditional ways of dealing with difficult issues in communities amongst the Native Americans, and shares common features with many similar circle processes (Yoder.2005). It is carried out over a period of two to three days with a group living and sharing meals together. During the course of the workshops, it was discovered that the victims are more at ease when they are all from the same community rather than a group of strangers, this allows them to gain the trust and respect sooner rather than later. In this way it differs slightly from conventional group therapies.

An initial evaluation of this approach indicated that 36% showed significant clinical improvement, and the sample as a whole showed significant changes in their psychological state (Reeler et al.2009). More complete information was available for a smaller sample [19], which showed 39% having significant improvement. On follow-up, 44% were still experiencing difficulties, with most [72%] experiencing economic difficulties. On the positive side, 56% reported coping better, only 9% reported health problems, and most were still connected to the group with which they participated in the process. All felt that that the process had helped them, had helped them learn new things, and had changed in the way that they felt about their torture.

A second study showed a stronger effect on outcome (RAU.2009).

Follow-up data was available for 58 cases, drawn mostly from two pre-urban areas in Harare. The sample was slightly more female than male [30 v 28]. The sample was mostly composed of mature adults [mean age: 39 years; s.dev: 13.9 years], reporting an average of 2.2 [s.dev: 1.2] human rights violations each. The violations were serious as can be seen from Table 2.

Table 2

Violation	Number [%]
Arson	1 [1.7%]
Beating	32 [55%]
Death of family member	7 [12.1%]
Destruction of home/property	27 [46.6%]
Unlawful Detention	11 [18.9%]
Abduction/kidnapping	6 [10.3%]
Rape	3 [5.2%]
Torture	3 [5.2%]
Other [threats, intimidation, etc]	35 [60.3%]

Torture and rape were only reported by 3 persons, but beatings [55%], destruction of property [46%], and other violations [60%] were commonly reported. This is a profile seen in many human rights reports, and especially those from 2008. (1)

The clients can thus be accurately described as trauma survivors. The highest improvement rate was obtained for the whole sample, which again was probably due to the presence of clients with non-clinically significant scores. The interesting finding was that, for the clinically severe group [10 or more], the improvement was markedly less.

Table 3

	Pre-test Mean[Sd]	Post-test Mean[Sd]	Improvement No[%]
Total sample [n=58]	10.43 [3.29]	5.67 [2.68]	39 [67%]*
Score [7 or more] [n=53]	11 [2.82]	5.91 [2.66]	34 [65%]*
Score [10 or more] [n=44]	12.76 [2.02]	6.82 [2.79]	15 [46%]*

**t-test: p=0.000001*

Statistical analysis showed significant change for all three groupings.

Finally, a contrast was made between men and women in the sample, but no differences were found

1 There is a very large literature on violence in Zimbabwe, and, for a selection dealing only with 2008, see the following: Zimbabwe Human Rights NGO Forum (2008), *If you can't join them, beat them! Post-election violence in Zimbabwe.* An alert of the Zimbabwe Human Rights NGO Forum & the Research and Advocacy Unit*. 5 May 2008.* HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2008), *Damned Lies? Post Election Violence in Zimbabwe*. Report produced by the Research & Advocacy Unit. August 2008. HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Solidarity Peace Trust (2008), *Desperately Seeking Sanity: What Prospects for a New Beginning in Zimbabwe?* 29 July 2008. DURBAN: SOLIDARITY PEACE TRUST; Solidarity Peace Trust (2008), *Punishing Dissent, Silencing Citizens: The Zimbabwe Elections 2008*. 21 May 2008. JOHANNESBURG: SOLIDARITY PEACE TRUST; CSVR (2009), *Subliminal Terror? Human rights violations and torture in Zimbabwe during 2008.* Report prepared for the Centre of Violence and Reconciliation by Tony Reeler. June 2009. JOHANNESBURG: CSVR.

between the two groups, apart from the finding, in the that men were more likely to improve overall than women, which seems to be implicating a vulnerability factor in the case of women.

In general, the findings are that there was strong statistically significant change in all clients in the direction of improvement following attendance at a tree of life workshop, which was evident three months later. When the mild cases [score less than 7] were removed, there was still a significant improvement found. All the rates of improvement were higher than those found in the previous study, which showed improvement in only 36% of cases; that is, only 36% showed a drop in scores below 7 on the SRQ-20.

The results show high rates of clear improvement for all persons attending tree of life workshops; that is, 67% overall show a drop in their SRQ-20 scores, but, when those with scores less than 10 are excluded, then the effect is not as great, but still greater than that found in the previous study – 46% as opposed to 36%.

The lower rates of improvement for the more severe cases are a cause of concern. Even though all the severe cases showed significant improvement (the scores on the SRQ-20 declined significantly), this was not below the threshold (scores of less than 7) for over half the cases. This speaks to the need for a referral system for tree of life processes and the need for careful follow-up of these cases as well as a second-level care system, where there is need for the availability of mental health professionals (Reeler.2008; RAU.2009). Ideally, this should be as close to the community as possible, and probably at the level of the primary care clinic.

The approach can be taught to survivors, results in the formation of small group affiliations, and can form the basis of cohesive groups around which other activities can be implemented. With the enormous displacements and political polarisation that have taken place over the past none years, it cannot be assumed that communities have maintained the cohesiveness that characterised many areas in the past, and hence it may be necessary to assume that a degree of community re-building will need to take place. The strength of approaches, such as the Tree of Life, is that they rely on people from the community itself, and creates a hub from which many other activities can develop. For example, the Amani Trust, in its programmes in Mashonaland Central in the 1990s, allied group processes to community development, and facilitated the creation of community agricultural projects that were highly successful.

Any community approach will need to interface with the formal health system in the end, so that the more serious cases can be referred on to professional help. However, it seems relevant to point out that both approaches can develop in parallel: improving or even creating the capacity of the formal health system to manage the needs of survivors can develop alongside the development of community-based assistance. Experience with Zimbabwean survivors in recent years has shown considerably more resilience than might have been expected from the literature, and hence there is reason to be optimistic that low-cost, para-professional approaches may go a considerable way to meeting the needs of the many thousands of survivors.

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