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Perceptions about implementation of a Narrative Community-based Group Therapy for Afro-Colombians victims of Violence

Percepções sobre a implementação de uma Terapia Narrativa grupal baseada na Comunidade para afro-colômbianos vítima da Violência

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Abstract *Given the context and the number of armed conflict victims in the Colombian Pacific coast and their difficulties to access psycho-social care, Narrative Community-based Group Therapy appears as a viable mental health intervention. The objective of this study is to describe the process of implementation and results of the intervention in Afro-Colombian victims of violence, in the municipalities of Buenaventura and Quibdó. More specifically, we will be looking at the perspectives of workers and supervisors, through evaluative case studies and individual in-depth interviews. The therapy allows us to identify support and coping systems through coexistence, communication and interaction. It requires an adaptation process to the diversity of knowledge and expressions of victims of Colombian violence, greater empathy from care providers and rigor in their profiles selection, facilities ensuring security and confidentiality, and links with other educational, employment and recreational organizations. It is important to include these results while improving current and future intervention processes.*

Key words *Mental health, Perception, Community mental health services, Violence*

Resumo *Dado o contexto e os números das vítimas de conflitos armado na costa do Pacífico da Colômbia, e as dificuldades de acesso aos cuidados psicossociais, a Terapia Narrativa de grupo Baseado na Comunidade aparece como uma intervenção de saúde mental viável. O objetivo do estudo é descrever o processo de implementação e os resultados da intervenção em vítimas afro-colombianas de violência, nos municípios de Buenaventura e Quibdó - Colômbia, a partir da perspectiva de trabalhadores e supervisores, através de estudos de avaliação e entrevistas em profundidade individuais. A terapia permite a identificação sistemas de apoio para o enfrentamento e o luto e através de convivência, comunicação e interação. Ele requer um processo de adaptação à diversidade necessária de conhecimento e expressões populares de vítimas da violência colombiana, maior empatia por parte dos prestadores de cuidados e rigor na seleção de seus perfis, instalações para garantir a segurança e confidencialidade, e links para outras organizações educacionais, trabalho e lazer. É importante incluir esses resultados na melhoria da intervenção processo atual e futuro.*

Palavras chave *Saúde mental, Percepção, Intervenção comunitária, Violência*

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Introduction

Colombia has experienced violence, militarization, and human rights violations since half century ago¹. The armed conflict has mainly affected rural communities, generating death, torture and displacement of survivors. Such violence has intensified on the Pacific coast during recent years because it is a strategic zone of interest for armed actors and illegal-drugs trafficking groups. This has displaced the Afro-Colombian population to urban centers of nearby municipalities, such as Buenaventura with 33,058 and 22,330, and Quibdó with 2,340 and 1,389 people expelled and received respectively in 2013¹.

Several studies and models have documented the relationship between context, violence, and impact on deteriorating victims mental health, as well as the effects on quality of life of individuals and communities. These actions have historically generated symptoms of depression, anxiety, post-traumatic stress and isolation, loss of family and social roles and difficulties relating to others²⁻⁵. According to theoretical models by World Health Organization (WHO), the etiology of mental disorders is multifactorial, being developed by the interaction of genetic, environmental, psychological and social factors. Social determinants are strongly correlated with mental health. Disadvantageous social conditions explain a relevant part the risks of mental illness. These conditions should be the focus of primary prevention strategies to stop the vicious circle of mental illness produced by social determinants^{6,7}. Accordingly, it is important to ensuring adequate and comprehensive care to victims of violence and their families².

In 2009, the Heartland Alliance International (HAI) organization, found that there are not enough offerings of mental health care according to the needs of Afro-Colombian population⁸. Since October 2010, in response to the situation, the following program was created: "Community Treatment Program for Victims of Violence in the Colombian Pacific - ACOPLE", was developed by Johns Hopkins University (JHU), the HAI, the National Association of Displaced Afro-Colombians (AFRODES) and CISALVA Institute of Universidad del Valle (CISALVA). All of these organizations were given support and funding from the U.S. Agency for International Development (USAID). ACOPLE seeks to provide treatment services, effective and culturally appropriate (previous qualitative studies of adaptation intervention protocols according to

custom and language of the region were done) near the Pacific Coast of Colombia. Among the services, it was offered the Narrative Community-based Group Therapy (NCGT)⁹.

The NCGT aims to train lay people from the community (Lay Psychosocial Community Workers – LPCW) to offer psychosocial support in mental health, under a supervising psychologist. In this intervention, the community participates and gives solutions to its mental health problems⁹. In the contexts of narrative therapies, people are considered as thinkable beings who give meaning to painful experiences through their language and interaction with others¹⁰.

This intervention consists of 12 sessions of two hours performed in community settings (schools, churches and community centers). The steps are to: 1) Conduct group dynamics, presentation and explanation of basic psycho-education rules; 2) Propose and pick the problematic issue for discussion; 3) Contextualize the subject and links to the suffering; 4) To exchange experiences, alternative ways of resolving and local knowledge on the subject; 5) Perform close and relaxation. Each intervention group consists of up to 25 participants and five LPCW, under the supervision and support of a psychologist and a social worker. The LPCW profile responds to survivors of Colombian conflict, with experience in community work.

Once the first phase of the evaluation process of ACOPLE was completed (quantitative), it is essential to describe and analyze the intervention as it is perceived, to provide feedback, improve the process, and implement intervention projects that really make sense in a social meaning¹¹⁻¹⁴. The present study seeks to describe the process of implementation and results of the NCGT intervention for victims of violence, in the municipalities of Buenaventura and Quibdó - Colombia, from the perspective of LPCW and their supervisors.

Methodology

Study Design and Population

Qualitative research was conducted, during 2014, through evaluative case studies of the project implementation process in Buenaventura and Quibdó, Colombia. This research was conducted in these cities, at the ACOPLE centers facilities.

Sampling was done for convenience with LPCW and supervisors of ACOPLE centers willing to participate. One LPCW was not reached

because she died. There were included eleven people, four in Buenaventura, six in Quibdó and one common to both cities, whose distribution is described in Table 1. This sample ensured the relevance and sufficiency of information reaching the representativeness and its saturation. Individual in-depth interviews were administered, recorded and transcribed. Also, field diaries with session notes were collected.

Procedures

According to WHO theoretical models -the ecological theoretical model of violence and the vicious cycle model of social determinants and mental disorders^{6,7}- three line of inquiry were constructed: 1) Presence of facilitators or barriers to the therapy participation/ performance, 2) Results of interventions and 3) Future applications and recommendations for intervention. From the lines of inquiry, an interview guide was designed. For the final structure of the instrument, a pilot tests were performed with two subjects different to the sample, but with similar profiles as the intended population. Cognitive interview strategy applied to make adjustments to the guiding questions. This technique, includes explanations of each question, information on the issues when answering questions or any other information that contributes to the question-answering process^{15,16}.

Data Collection

Data was collected between June and August 2014. Interviews lasted 30-60 minutes, with two meetings per participant. Clear and simple language was used for questions; thus, they could be answered with simplicity and assertiveness by interviewees. Interviews were conducted in safe environments that promoted trust and responsiveness by respondents. Confidentiality and

anonymity were kept using codes. Interviews in Quibdó were carried out in-situ; for Buenaventura, they were by video-calls due to security issues in the city.

Data Analysis

Transcripts of individual in-depth interviews, followed by an empirical and conceptual debugging, and a narrative content analysis (selective categorization) were conducted through Open Code® Software, Version 4.0. This resulted in the identification and development of several core categories. This process was carried out under a summary review, verification and confirmation, allowing for different views of the same reality, according to the study objective.

The data analysis was characterized as a process involving two analysts continuously, which ensured a rigorous process and reducing bias in the interpretation and consistency thereof. Coding and data analysis was carried out permanently, resulting in the feedback information.

In order to further ensure methodological rigor, a validation process through peer review was conducted in addition to the the triangulation of information.

Ethical issues

This study is part of the “ACOPLE” study, which was approved by the Institutional Board Review of Human Ethics of Universidad del Valle, Colombia. Consent was obtained from all participants before the interviews. Specifically for this paper, no contact was had with the participants of the randomized control trial.

Results

Four core categories were formed in order to organize the emerging concepts: 1) Community and society, 2) Resources and infrastructure, 3) Managers and project staff and 4) Effects and results. Categories 1, 2 and 3 were facilitators or barriers of the intervention effects, which were addressed by the last category (Figure 1). Emerging concepts are explained as follows, according to theoretical models and repeatability of information, covering both individual and contextual levels to describe possible causal factors and effects:

Table 1. Distribution of the total study sample.

	Buenaventura	Quibdó
LCPWs	3	3
Psychologist	0	1
Social worker	0	1
Coordinator	1	1
Director	1*	1*

* Person in common for both municipalities.

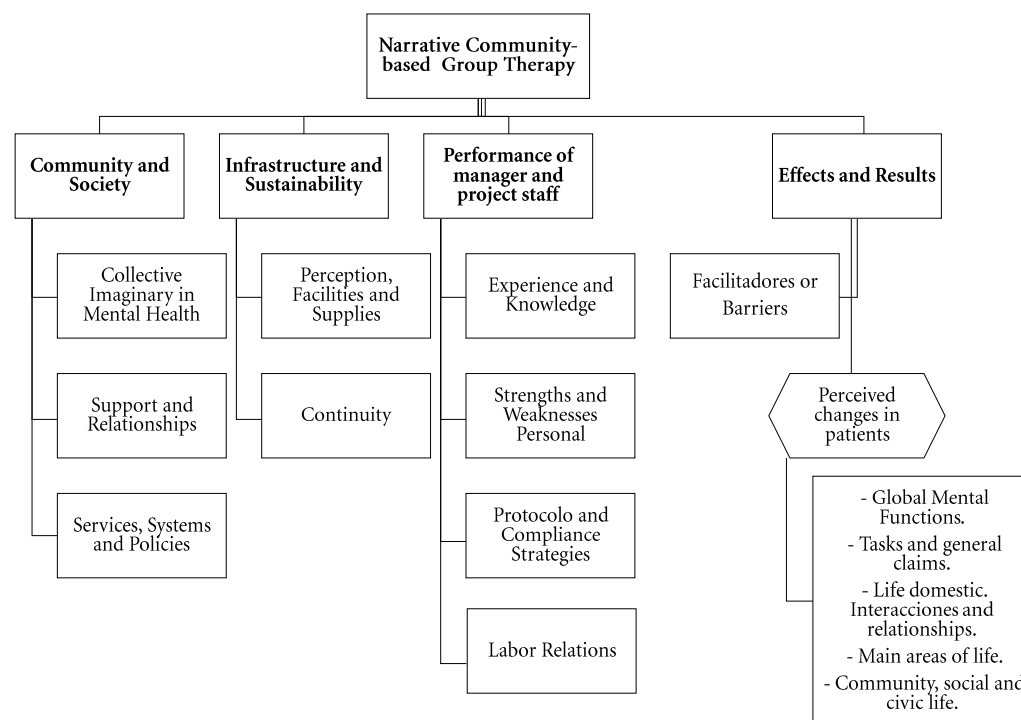


Figure 1. Qualitative Analysis categories.

Meaning of mental health within community and its social context

“They thought they had to deal with the problem only by themselves” ACQ001

According to respondents, mental health is seen as an individual situation, unconnected to the social issues in the community, generating feelings of isolation, rejection, shame, guilty and being judged among the affected persons, which may create barriers for the recognition of mental health promotion in the community. This situation makes people consider mental health as a concept related to “mad” people, which causes compliance difficulties among NCGT users.

“They were influenced by strong social stigma about madness: <I’m not crazy, what are you talking about?>, <And if my neighbors know I’m attending psychologist, what will they think about me? >” GQ003

However, the NCGT seeks to break these social paradigms. The ACOPLE project seeks for an adaptation process to the diversity of communities’ knowledge, in order to respond to their mental health needs, promoting effective, replicable and tailored interventions. The initial adaptation

process was performed before the NCGT implementation, through qualitative studies, allowing intervention protocols to be adapted according to the customs and language of the participants. For that, free list, focus groups and key informants interviews, methodologies with community leaders, potential participants, and LPCWs were conducted to explore the problems of survivors and the possible solutions or activities that they do to take care of themselves, their families and community. With this information, and the feedback of the community, the intervention was designed, to be appropriate for improving the mental health and life conditions of survivors in the region. Nonetheless study respondents considered that the adaptation work needs to be improved.

“I think we have not reached the culturally appropriate process yet, [...] there are rites and customs we could implement and they could have a healing effect on persons and may not have been using it yet” GQ004

Likewise, therapy seeks to generate effects through interaction and language, in response to particular social and political context that has generated violence, displacement, and unem-

ployment in Buenaventura and Quibdó, so the NCGT becomes a construction element from a given context.

"Sometimes they said <When I come here I feel good, emotionally relieved, but coming back to my neighborhood, to my home, I read the newspaper, or people tell me a story or watch the news and my world collapses again>, then I think it was a complex situation because the violence [...] it is permanent "GB001

Resources and infrastructure

For those interviewed, facilities must be secured with three characteristics: breadth, security and confidentiality. This will generate feelings of trust and freedom of expression on the part of patients. Not having a fixed place, could create logistical difficulties and restrictions, affecting in some way continuity and patient care. According to obtained testimonies, although these facilities were adequate in some cases, respondents expressed the need to better security and confidentiality, which would facilitate appropriate intervention processes. In Quibdó, greater variability and lack of a fixed place is presented, which generated crosses with work schedules of patients, affecting treatment compliance by users.

Work team strengths and weaknesses

"How do we take away their sadness of losing their territory, having left their beloved death unburied?"ACQ003

An ideal profile for LCPW should include education, experience, emotional identification and characteristics of a community caregiver. According to respondents, knowledge and preparation was sufficient and appropriate for some participants; others had little training and low in terms of subject and academic levels. As for experience in projects and social organizations, both were higher in Buenaventura and less in the city of Quibdó, which could favor the development of counseling and emotional support skills. As for the emotional identification and therapist-user relationship, empathy was the feature most represented in the stories obtained; due to LCPW having been survivors of violence, this fact favored their emotional identification with users of the NCGT.

"Most LCPWs lived traumatic experiences, they are also primary survivors, and they have to talk about these issues with people who experienced them too [...] [which] was an advantage, because

LPCWs could create empathy and emotional identification with the people "GQ003

Moreover, as to the characteristics of community mediator, they understood as a vocation for collaboration, listening, emotional support and advice to others, Quibdó was characterized as a team of leaders with a strong recovery of duties and less on emotional support, contrary to Buenaventura's team which had more community caregivers.

"Some people actually participate in the project because it is a work opportunity, not because they are interested [...] they were some people who had some skills, which had some propensity to be community caregivers, but others definitely had not "GQ003

Sum of uniqueness and individual effects

"And they have learned how to live their life, not to forget, because it is not forgotten, but they learned how to survive"ACB003

According to the testimonies, users were people with few skills for handling difficult emotional situations. They had limitations in terms of coping with stress, anxiety, sadness or fear, for solving problems and making decisions, for performing general tasks and demands, and finally, they have restrictions in social, civic and community life.

In this line, all LCPWs identified positive changes in users, who at the end of the process showed decreased feelings of sadness, anger and life disinterest, as well greater functionality, appearance changes and increased participation during therapy sessions, plus the desire of users to teach others what they have learned.

"Now they could socialize, because sometimes they were shy, they learned how to express their feelings: <With therapy I learned how to speak, now I have my job, and I go out, I can talk with my neighbor and I am feeling better> "GQ001

Respondents identified the recognition of social networks through coexistence, communication and interaction with peers, as the predominant change in users. Through the NCGT, users had the opportunity to find different solutions to the same life problem, as well as practical and functional life issues, in addition to identifying the purpose and value of adversity. The network and the possibility of building support groups allows users to share experiences, successes, failures, information and resources.

"After finishing therapies sessions, they could say: <I learned that I am not alone, I learned that

I have another one support, I learned that my neighbor share similar problems with me, so I can learned of it>" GQ002

*"After two years (...), I found one user, she told us: <Hey, I still do my relaxation exercises>, and she said <I can already change my negative thoughts>, so, there were many changes in users and community."*ACQ003

However, the effects were not evident in all users, situation related to their motivation, support and compliance of the therapy. Some participants seemed to attend meetings because of a commitment with someone else, and did not participate by their initiative. Similarly, work and social situations made it difficult for some users to attend. Social and cultural context of cities, lack of support from institutions and local authorities and staff's mood were also mentioned as possible causes.

For some LPCWs, mental health needs were not satisfied with this intervention, due to the sociopolitical context in which users live. Hence the suggestion to facilitate links with other educational, employment and recreational organizations, would create social opportunities and new supporting networks.

*"After 4 or 5 sessions that we saw that a user could talk about his son's death without cry, we said: <we did something positive because this person can live with the memory, but now it does not hurt him so much"*ACQ003

Discussion

In Colombia, in 2011, a law was passed for implementing mental health rehabilitation programs, which include individual and collective therapies, for promoting mental health and social relations among the population affected by violence¹⁷. Given the number of victims and their geographical spread, it is difficult to achieve an appropriate coverage of psychosocial repair services in the current Colombian context, a situation that also occurs in other low-and middle-income countries¹⁸. Thus, NCGT therapy appears as an alternative that may contribute to improving the coverage of mental health services, but according to this study, there are different factors that affect, positively or negatively, the NCGT therapy implementation. These factors are consistent with spheres and dynamics proposed by theoretical models^{6,7}, in which the context (inequities and stigma), exposure to stressful events, social and economic position of the individual and vulnera-

bility of ethnic minorities, impact on health conditions and the results of such therapies in terms of access, social and cultural barriers, adhesion and improvement¹⁹.

Within these factors, cultural knowledge in Quibdó and Buenaventura about mental health concepts affects the compliance of therapy by the users. Culturally, a mental health problem generated a label, stigma or devaluation in affected people^(20, 21). This stigmatization, according to the Colombian Pacific lay knowledge, generates negation of the condition with victims suffering due to their fear, shame and guilt. This can cause victims to be hesitance when they talk about their traumatic experiences and a restraint of searching for required care services²⁰⁻²². However, the formation of a group like NCGT allowed for greater effectiveness in the fight towards eradicating the stigmas associated with psychological problems. The rupturing of these imaginary judgments is of the greatest achievements of this therapy.

Also, our findings indicate that it is an essential part of the therapy, to ensure safe locations where participants can discuss trauma and violent stories. It should establish a safe therapeutic place that encourage users to participate, interact and express themselves, and allows to create group identity and contribute to adherence of intermittent population^{20,22,23}.

Similarly, factors like profiles and skills of LPCWs can affect the therapist-user relationship. In this study, working with community members staff, built confidence, intercultural dialog, and supporting networks. In addition, empathy of LPCWs was highlighted, which is a skill that has been documented as a fundamental for improving the mental health of patients^{23,24}. In Buenaventura, LPCWs had experience in religious and community processes, which could explain better results in quantitative analysis compared with Quibdó⁹. Although a religious approach was not part of the NCGT protocol, religiosity may promote greater motivation and listening skills by LPCWs, as it has been demonstrated by the literature^{23,25}.

As for the effects reported by respondents, and according to the results of the other quantitative study⁹, NCGT users showed improvement in functionality and performance of family and social roles. This is consistent with studies that through group activities, people changed the way they perceive themselves and their environment, as well as restoring personal truthfulness and self-control^{21,23}. Also, the positive effects of communication processes have been demonstrated²⁶,

which, through the language, enhance attachment and emotional bonds as mental health promoting factors^{27,28}. Users who share their traumatic memories in a safe environment, cohesion and empathy provided by other patients and the therapist himself, can utilize the experience and propose solutions or alternative scenarios, contributing to the consolidation of support spaces for the emotional.

Despite the results, according to interviewees, users' mental health needs were not totally satisfied, due to repetitive and systematic exposure to violence and lack of working opportunities in both cities; this is consistent with the dynamics between individual and contextual fields of theoretical models, in terms of mental health^{6,7}. It has been demonstrated that there is a need to improve social relationships and neighborhood environment for violence survivors, and also to create decent employment conditions for them²¹. Violence survivors' abilities to carry out productive social and economic activities may be influenced by political factors and work-related opportunities, instead of their previous traumatic experiences. Therefore, it is necessary to fulfill these needs, by means of human rights restoration processes^{22,29,30}. Also, it is need to understand the importance of this local context to create valid instruments and locally appropriate interventions³¹, taking into account healing, living and coping traditions of Afro-Colombian communities³².

The study has some limitations: Findings cannot be generalized different cultural settings,

but it helps to implement community-based interventions for violence survivors in similar contexts. Additionally, findings related with NCGT may be biased because interviews were performed with the LCPWs, without users' participation; however, the aim of the study was seeking to contribute to the implementation process, instead of focusing on NCGT effects. Still, it is recommended to analyze the perceptions of users in future studies.

To our knowledge, a strength of this study is that it is the first to analyze the implementer's perceptions about community-based mental health interventions in contexts of poverty and active armed conflict. Thus, this study provides useful insights for implementing future community-based mental health programs.

In conclusion, NCGT can reach more users in comparison with individual approaches. Also, it had a good performance in community settings, generating integration and enhancement of social support to solve the mental health needs of violence victims. This intervention helps to restore social function skills that were lost or damaged by violent and traumatic events. However, it may not be sufficient by itself; therefore, integrating different intervention strategies is suggested to improve mental symptoms and function altogether, within active internal conflict settings. Finally, it is important to include popular expressions for coping with violence as a collective rehabilitative strategy for Afro-Colombians victims of violence.

Collaborations

GV Osorio-Cuellar worked in the study design, data collection and the drafting process of the manuscript. SG Pacichana-Quinayaz participated in the study design and contributed to the drafting of the article. FJ Bonilla-Escobar and A Fandiño-Losada participated in the study design, supervised the research process, made critical input on the manuscript and approved the final version of the same. MI Gutierrez-Martinez participated in the study design, critical reading of the manuscript and approved the final version.

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