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Group Therapy Model for Torture Survivors: A Case on the Ghosts of 82-IMLU

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Abstract This article discusses Group Therapy Model in addressing the long term effects of torture as applied in resource poor setting in an emerging democracy in Sub Saharan Africa. The group therapy model was implemented by the Independent Medico Legal Unit (IMLU), working with **56** ex Kenya Air-force soldiers who were subjected to brutal torture following a botched coup attempt in 1982 in Kenya. The model engaged **9** survivors as peer counselors who worked hand -in-hand with trained trauma counsellors to support their counterparts in the Nyanza region of western Kenya. IMLU, - one of the leading centers against torture in Africa, provides psychological rehabilitation, medical treatment and legal support to about 500 survivors and victims of torture and their families annually, through national network of 53 trauma counselors, 70 medical doctors and 100 lawyers across Kenya. Historical torture leaves its mark, and survivors struggle to cope with the impact of torture, up to decades later. The long term psychological and social impact of torture include ongoing PTSD [1] symptoms (flashbacks, nightmares, anxiety, and depression), substance abuse, suicidal ideation, hopelessness, family breakdown and lack of integration into society (Blanchard et al., 1997) [1]. In addition, torture leaves scars even decades later, affecting families, even communities as was evidenced working with the group of soldiers' spouses. As part of IMLU's support, full medical assessments were conducted to determine the extent of the torture on the **56** ex Kenya Air-force soldiers. By the end of the 10-week group therapy, there was a 42% reduction in symptoms across all categories of physical, behavioral, PTSD, Anxiety and Depression- A clear indication that group therapy, coupled with medical, legal and social assistance played a pivotal role in the healing process for the ex-soldiers.

Keywords PTSD, Group Therapy, Torture, Peer Counselors

1. The Sequel of the Torture, Post- 82' Coup Attempt

In 1982, a coup was attempted in Kenya in an effort to overthrow the then President Daniel Moi's government. On 1st August, a group of soldiers from the Kenya Airforce took over the radio station *Voice of Kenya*, announcing that they had taken over the government. The group tried to force Airforce pilots to bomb the State House at gun point. However the pilots did not follow those orders; instead dropped the bombs over Mount Kenya's forests. One Senior Private Grade-I by the name Hezekiah Ochuka, the mastermind of the attempted coup escaped to Tanzania but was later extradited back to Kenya, where he was tried, found guilty and hanged in 1987. Following the botched coup the entire Kenya Air Forces was disbanded. A total of 12 people were sentenced to death, with more than 900 being jailed. Those that were hanged were buried at the maximum security prison. The then Kenya Army Commander, General Mohammed ordered the arrest of those that were suspected of taking part in the attempted coup. The men who were arrested were then taken to the Lang'ata Army Barracks where they were beaten with crude weapons and tortured mercilessly. The arrests were conducted by the Kenya Army with orders from the Army Commander, who was acting on the premise that their colleagues in the Air-Force had become traitors of the Nation. The arrests were conducted in the most haphazard manner and many were shot and injured in the process.

The Air-Force survivors of the torture following the attempted coup sought IMLU's support in 2014, 32 years after this atrocious event. A Group Therapy Model was

[1] *PTSD* is a mental health condition that's triggered by a terrifying event — either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.

employed in addressing the long term effects of torture, working with a total of 56 ex Kenya Air-force soldiers. The model engaged 9 survivors as peer counselors who worked hand -in-hand with trained trauma counsellors to support their counterparts in the Nyanza region of western Kenya.

A total of 56 men were supported (the pioneer group of 9, an additional 47 in the Nyanza region) and 9 females-spouses of the first group of 9 men. On admission to IMLU's therapy program it was apparent that the current circumstances of these victims such as poverty, inability to find meaningful work or sources of income, health complications, loss of property, strained family or close relationships among others, had contributed heavily to current psychological challenges, hence exacerbating existing problems for this particular group such as acute anxiety, PTSD symptoms and depression (Amris & Williams, 2007). [2]

As part of IMLU's support, full medical and psychological assessments were conducted to determine the extent of the torture. Given the complexity of the health and social consequences of torture of victims' coup and due to their geriatric profile, it was difficult to define the physical long term consequences attributable to their original injuries.

The physical assault reported by these victims included being forced to walk on their knees on concrete floors for hours and whipped before being bundled into a dark overcrowded cells where they were kicked around, and bludgeoned all over their bodies with various blunt objects including gun butts. Additionally from the history of the incident, some of these ex-soldiers were submerged in dirty water for days on end while naked, without food, and water. Most of these men sustained bruises from blunt force trauma, cuts, upper respiratory illnesses visual and auditory defects and a few reported fractures.

Among the multitude of problems presented by these ex-soldiers, persistent chronic pain in the musculoskeletal system was the most frequent physical complaint. Most of the presenting complaints described regional or widespread muscle pain and joint pain especially in the knees which they attributed to being made to kneel or walk on their knees for prolonged periods or due to physical blunt force trauma to the lower limbs. Pain related to the spine and neurological complaints such as numbness and paresthesia were also common. The main disability from this chronic pain is being inability to carry simple movements, sleeping disorders and generally reduced quality of life.

Headache and back pain which were linked to severe beatings were frequently reported. Most of the pain symptoms described by these soldiers could be grouped into clusters but difficult to pin into a specific diagnosis. A few of these pain symptoms could be alluded to direct injury to the musculoskeletal system, strain on the musculoskeletal system, altered central pain modulation, neuropathic pain or somatic symptoms.

From the history, it appeared that several of these soldiers had sought treatment for their chronic pain but these symptoms had been dismissed by a number of medical practitioners possibly due to the assumption that these chronic pain symptoms were the somatic manifestation of psychological disturbances. Very few of these torture survivors have had access to specialist pain management services.

A large number of these survivors of torture complained of reduced hearing or complete hearing loss which they said was a result of boxing or clapping the ears. A few of these cases demonstrated scarring of the tympanic membrane on otoscope examination. Visceral symptoms (cardiovascular, respiratory, intestinal, and urogenital complaints) were also highly reported. However while highly prevalent, these nonspecific symptoms could not be linked to the original assault and neither could the high number of visual disturbance symptoms which the ex-soldiers presented with, as was documented in the medical reports' case files.

Scars were the most common sign of physical torture with a high number of attributable scars being documented. Other physical findings included increased tender and trigger points in postural muscles; tendonitis, tenderness and restricted range of movement in peripheral joints and the cervical and lumbar spine. However most of the muscular-skeletal and neurological examinations did not yield much in terms of specific findings that could be linked to torture. The severity, extent and repetitiveness of the original trauma was hard to categorize. A discrepancy between the much-reported subjective pain complaints and scarcity of objective findings in these elderly soldiers, combined with relative unfamiliarity with chronic pain mechanisms, led to the widespread conclusion that these symptoms existed within a psychosomatic framework. IMLU's medical review took place 32 years later when most symptoms were being reported as a chronic sequel of this physical torture. A large group did not present with any physical evidence of torture cruel inhuman or degrading treatment however this in no way implies that these victims were not physically tortured.

Of critical importance was that most of these ex airmen felt that the importance of their psychological problems had been over emphasized with insufficient recognition of the value of medical assessment. Knowledge about chronic post-torture pain is not widespread among most medical practitioners and research in chronic post-torture pain should therefore be clinically relevant, aiming at identifying relationships between pain and a number of clinical, functional, and psychosocial factors. These cases emphasize connections between physical and psychological trauma and the importance of an interdisciplinary approach to torture treatment.

Medical and psychological support is a key component in the rehabilitation of torture survivors. This often is combined with legal and or social support. Medical

assessment and treatment, counseling at both individual and group levels, are essential components of the healing process for victims of torture. This approach is anchored in IMLU's work in supporting victims of torture as well as their families.

2. Group Therapy

The power of the group can never be underestimated. In the African context for example, studies have shown that adherence to Anti-Retroviral Therapy (ART) for People Living with HIV Aids (PLWA) improved significantly for survivors who were part of a group support in comparison to those who were not part of a group support.

In Psychotherapy, since the advent of support groups such as Alcoholic Anonymous and Cocaine Anonymous, group therapy has continued to be used in hospitals and with military veterans to mention but a few. According to Irvin Yalom (2005)[3] in his book, *The Theory and Practice of Group Therapy* in which he advocates for the power of the group in psychotherapy, he asserts that "There is persuasive evidence that the rate for virtually every major cause of death is significantly higher for the lonely, the single, the divorced and the widowed. Social isolation is as much a risk factor for early death as obvious physical risk factors such as smoking and obesity. The inverse is also true: social connection and integration have positive impact on the cause of serious illness such as cancer and AIDS. (Yalom 20, 2005)" [3].

According to Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, peer support is an intervention that leverages shared experience to foster trust, decrease stigma and create a sustainable forum for seeking help and sharing information about support resources as well as positive coping strategies. Peer support is assistance provided by a person who shares commonalities with the target population, for example, direct experience in a particular situation or event, familiarity with a particular stressor, or other shared characteristics.

Trauma is an extremely distressing experience that the mind cannot make sense of at the time and which disrupts the body's natural equilibrium throwing the nervous system into overdrive. The experience ruptures the survivor's sense of predictability and invulnerability. Van der Kolk (1997) [4] observes that it is a result of exposure to an inescapably stressful event that overwhelms a person's coping mechanism. The 82' coup survivors had shared concerns about feeling stigmatized especially because they felt that the then regime of the day had branded all ex air force servicemen, serving at the time of the attempted coup, as rebels who wanted to overthrow the government. The intention was that once this cohort had been counselled and then trained as peer counsellors, the peer support program would facilitate opportunities for their former colleagues in the military to be supported. The peer support program could also offer educational and social support as well as provide avenues for additional help if needed.

Over the last 2 years IMLU provided rehabilitation in the form of group therapy to these survivors of torture. The first set of 9 survivors who sought IMLU's aid was taken through medical and psychological counseling. When they reported to IMLU, these survivors detailed that the torture they endured devastated not only their lives, but those of their families and community and that they would benefit from the opportunity to attend therapeutic groups to aid the healing process. Upon completion of the therapy, it was apparent that there was need to support their counterparts, in their thousands, spread out in various counties. There was therefore need to think through how this support would be implemented. The peer-counselor approach was then employed, with the group of 9 ex-service men.

Working in conjunction with professional trauma counselors to roll out the program, they would offer key components of social support, credibility, experiential knowledge, trust, confidentiality and easy access-to the colleagues in various counties. Worth noting, is that some of the group members in this cohort of peer counselors were already instrumental in the attempts of assisting their former colleagues in the pursuit of justice through legal redress in courts. This is also consistent with the criteria of screening peer support counsellors for successful peer support programs as highlighted by Keller (2005) in her article *Soldiers Peer Mentoring Care and Support: Bringing psychological Awareness to the Front.*

In many cases, the individuals who become peer counsellors are those who already are un-officially filling this role; they are known as a person who will always listen. The formal program therefore only provides recognition for the work these individuals are already doing and would train them to enhance their natural ability to provide support. The training for the 9 peer counselors took place over a 10 week period; it was both content and skill based. The content included general information on counselling and group therapy approaches to counseling. The cohort was made aware of ethical considerations in counseling as well as other available resources that they or their colleagues could access while facilitating the peer support groups. The skills-component which for the most part was delivered experientially included topics such as effective listening as well as how to co-facilitate a group session.

The 9 men were then paired with IMLU's trauma counsellors to deliver group counselling to the remaining survivors. Providing psychosocial support to the thousands of survivors across the country represented a unique challenge and opportunity to address rehabilitation for historical injustice as well as establishing practices when providing psychological, medical and legal support to large groups of survivors of torture and ill treatment.

A mapping of the locations with a high concentration of

survivors was done across various counties, with the majority of the men being in the Nyanza region. The first sample of 47 men were screened and taken through initial individual psychological assessments, to ascertain the need for either group or individual therapy. This was also done in order to group the members in smaller therapy groups based on the key identified psychological issues.

The assessment was one developed by the Centre for Victims of Torture (CVT) and used in all of their international programs to assess the impact of torture. CVT had given permission for IMLU to utilize these assessments and they focused on 5 key areas: Physical symptoms, Behavioral functioning, Anxiety symptoms, Depression symptoms and PTSD. At the beginning of the group, 47 men underwent the assessment and were then taken through group therapy, with all the men grouped into 4 groups in the Nyanza region of Kenya. It was noted at the beginning of the groups that most men had high scores in the Depression and PTSD categories and the groups were designed to provide therapy to decrease symptoms in these categories.

These psychological symptoms can often be debilitating and many of the men reported having resorted to self-medication and other means of combating the symptoms. The men also reported having struggled with acute stress, anxiety, PTSD symptoms, and depressive symptoms. The majorities of the men had not disclosed their ordeals to family members and thus were not able to benefit from family or social support which could have offered them some relief.

They had experienced multiple traumatic experiences that included torture at the hands of their fellow military officers as well as prison wardens. They all reported that since the exposure to the traumatic events, most of major symptoms had persisted and that they had not been able to resume their previous level of functioning. The similarity in the torture environment and methods, the fact that they were all ex-military men serving in the same camps, and their age groups were the key factors in grouping them for therapy, in addition to providing an enabling environment for group support and cohesion-majority of these men had lost contact for over 30 years, save for the few who had in one way or another managed to stay in touch.

It is worth noting that an individual's reaction to emotional trauma is complex and difficult to predict. A person's age, past exposure to trauma, social support, culture, family psychiatric history and general emotional functioning are some of the variables related to individual response to trauma (McFarlane & Yehuda, 1996) [5]. Other variables include the emotional and physical proximity to actual danger, the degree of perceived personal control, the length of exposure to the trauma, the reaction of others to the trauma, and the source of the trauma.

Friedman (1991) [11] postulates that nearly always all PTSD treatment should include psychotherapy (group or individual) peer group participation and family therapy. He adds that models of psychotherapy that have been used to treat former military personnel with PTSD can be broadly divided into psychodynamic treatment and cognitive-behavioral treatments. Yalom D 2005[3] supports this by citing catharsis, altruism and instillation of hope as some of the main outcomes of group therapy. According to Van der Kolk [4] and McFarlane (1996) [5] a large number of trauma survivors presents with reactions of horror, helplessness and intense fear.

At commencement of group therapy, most of the members appeared uptight, lethargic, edgy and paranoid. They seemed to be in a state of psychological disempowered, disconnected and had internalized a sense of self blame. During the first month of therapy, the therapist had a sense that somehow the members were sizing him-up. In some ways, the group members' interpersonal relating styles evidenced the indelible marks from the severe violations they had been subjected to. The group later confirmed initial thoughts that they felt very insecure and vulnerable in the first month of therapy, that they didn't trust the therapist or the organization; they harbored doubt about Independent Medico- Legal Unit (IMLU) and value of therapy in their lives.

The most common symptoms reported by members included persistent nightmares and flash backs associated with the themes of the traumatic events (Keller, Saul, & Eisenman, 1998) [6]. Other times, the nightmare seemed illogical with inexplicable themes, debilitating fear, startled reactions, getting overly aroused by military activities and annual commemorations, anger, irritability, shame persistent sensitivity toward specific military locations, sleep disturbances and/interruptions, long spells of being dazed - derealisation and various ailments/physical conditions.

The survivors seemed trapped in a cycle that reinforced avoidance of situations and places that triggered anxiety without a way out; which is characteristic of trauma survivors (Cunningham, & Silove, 1993) [7]. One of the group members summed up his traumatic experience and the effects as "living in a dark tunnel." Other common issues that were not verbally reported but were revealed in the course of therapy included severely damaged self-concept which was characterized by an extremely low self-esteem and a diminished sense of self-image. Owing to their experiences, the clients were defining themselves against their torture and traumatic experiences. A good number had resigned to living life a day at a time with a bleak and blank sense of the future.

Based on the torture experience of the survivors and the symptoms they were exhibiting, the goals of therapy were to help the individual group members:

- Acknowledge the traumatic experience by retrieving traumatic memories and review them in group sessions
- Express emotions
- Learn to deal with memories and feelings

- Master trauma symptoms
- Deal with self-concept issues and interpersonal relationships
- Find hope and meaning in life

Studies suggest that the philosophical approach and personal attributes of the counsellor largely determine the nature and outcome of therapy. For this reason, the group therapist underpinned his therapeutic work on an eclectic model with a foundation on client centered approach.

Carl Rogers opines that certain characteristics are essential for effective treatment in trauma and in establishing a working alliance; he cites these as unconditional positive regard, genuineness, and accurate empathy. Research has shown that an empathic therapist style is associated with more positive long-term outcomes. CBT, Exposure and Existential based assumptions, and skills were integrated as and when deemed appropriate.

From the onset the relationship between the clients and the therapist was based on Carl Rogers' core conditions of therapeutic relationship, namely- accurate empathic understanding, unconditional positive regard and genuineness which laid the basis for safety and trust within the group. According to the group facilitator, this enabling environment could be attributed to the clients' "*risky talking"*.

The therapist's philosophical approach proved very beneficial and useful as it was amenable to every phase of therapeutic process. The healing process constituted three stages– safety and stabilization, remembrance and mourning and reconnection. The therapist combined principles and techniques from Judith Herman's [12] model of healing and narrative exposure therapy to facilitate the clients acknowledging and coming to terms with their traumatic experiences and the effects in their lives.

The central component of treatment involved processing and acknowledging memories of the traumatic events. This was conducted when enough safety and a solid therapeutic alliance had been established and the clients were not in danger of being re-traumatized or over stimulated by their materials.

The group members were also empowered with knowledge and skills on the symptoms management/coping strategies and self-soothing skills. As a result, group members felt safe to recount stories of their traumatic events in a holding and supportive environment. Judith Herman [12] postulates that recounting of the traumatic events facilitates clients to incorporate the traumatic memories into the fabric of their overall life story. She observes,

> *"When a victim/survivor tells the story of his or her trauma, in detail and depth, this action can transform the traumatic memory so that the survivor can then integrate the memory into his life story. What was once overwhelming, unspeakable, and unassimilated is transformed and incorporated into the life story of the survivor, thereby empowering the survivor to no longer be held captive by the trauma and to regain authorship of his/her own experience and life."*(Trauma & Recovery, 1992).

During this phase the clients were also able to work through the process of loss and grief, they engaged in rituals which facilitated acknowledging both tangible and intangible losses. Ritual and art based techniques proved to be useful since the socio-cultural perception of men (African) discourages men from becoming emotional. It was easier for them to work through loss through rituals and art work which enabled them to stay grounded and to allow themselves to feel what they felt when they felt it.

Additionally, exposure to positive, enjoyable experiences was helpful as a way of repairing the sense of having an injured/damaged self and as a way to counterbalancing a survivor's preoccupation with the past horror. The group members observed that besides their experiences of therapy, the three experiences, namely a narrative exposure therapy session, peer training workshops and a group termination event stood out as some of the post –positive experiences in their lives.

According to the survivors, these are some of the few times in their lives they have felt valued, accepted, cared for, and esteemed as human beings. These experiences somehow elevated their sense of self and were instrumental in supporting them to reevaluate and redefine their self-concept accordingly. Van der Kolk et al (1996)[4], observes that clients need to find experiences that provide them with feelings of mastery, success, and pleasure. Engagement in physical activities such as artistic accomplishments, and so forth can help the person feel less "*contaminated"* by the trauma and can help him or her to have a more positive sense of self.

It is assumed that healing from trauma or trauma resolution occurs when the client can remember the trauma, without being overwhelmed by it (Yalom, Irvin D., with Leszcz, M. 2005) [3]. The client will then be able to tell the story of the shocking event without re-experiencing it – and as such, the event becomes a historical event (i.e., an event that took place in the past) and the person no longer feels (or reacts as though) it is still happening now.

3. 82 ex -Soldiers Wives' Group

Trauma not only affects the individual both physically and psychologically; it affects those around them-family members, and significant others. It became apparent during the group therapy that the members had endured painful experiences in silence, having not disclosed this to their partners, despite the fact that their absence while away in custody and even the change in their behavior once they returned, affected their family members. Of particular interest to this group was their spouses whom they felt would benefit from some kind of support whether on a

group or individual level. For the 9 men as was the case with the rest of the men in the other regions, their relationships and marriages became strained and distant.

Most of the wives became their families' bread winners; taking care of their young children in the absence of their spouses, with very little information on what befell their husbands. Consequently most of them harbored bitterness and anger towards these men, who had gone through more pain than they could bear to disclose. Counseling for their spouses was therefore embedded into the program for the ex-army men. The joint occurrence of trauma and separation has a significant impact on emotional distress and family relationships, and the support extended to families and loved ones plays a pivotal role as an anchor of emotional stabilization and healing (Aroche, J, & Marin, L, 1994) [9].

It was therefore agreed that ethically, the 9 men were not the best placed individuals to support their spouses, with the obvious risk of developing a dual relationship. This informed the programme towards formulating a therapy group for secondary survivors under the facilitation of two female IMLU Network Counsellors. The women were then taken through ten sessions of group therapy.

The main goal that presented during the onset of the group therapy was supporting the women to vent their anger and frustrations following their loss, especially developmental losses, during their spouses' arrests and subsequent incarceration. Catharsis [2] was the main approach used during the group sessions and by the end of the sessions, the women had learnt how to confront and manage the negative emotions that had manifested for the 32 years. The women were empowered with the use of relaxation techniques and encouraged to embrace social support (Schauer, et al., 2011) [10] amongst themselves as a way of enhancing healing not only to themselves but to their spouses and children.

Psycho education on how to handle both criticism labeling and sympathy was conducted to enable the women to cope with the ripple effects of the ills their spouses had suffered, given the fact that a documentary on the 82 Group of Soldiers that was aired on one of the major Television channels in the Country. This was very vital since the documentary was received with a myriad of mixed reactions from the public and this was found to be a stressor to the affected families.

The group was terminated upon completion of the scheduled ten sessions. During termination, the women had started working towards economic sustainability. They felt that the group was extremely beneficial, with many reporting that they feel much 'lighter' and less burdened by the pain, and frustration of having to take charge where they felt their husbands had *failed*. They felt that with the therapy, it would be easier for them to talk about what transpired with their spouses, and how their lives changed, without feeling the need to place blame on each other, but rather find this an opportunity to rebuild scarred relationships with a brighter hope for the future.

4. Results

The group therapy was extremely beneficial in allowing the members to talk about, many for the first time, the impact of the 1982 coup and the events that followed. By the end of the group therapy sessions, the men were taken through the same psychological assessment they did prior to the onset of the sessions in order to determine the impact (if any) of the therapy. The results showed that there was a 42% reduction in symptoms across all categories of physical, behavioral, PTSD, depression and anxiety. The table below shows a summary of the scores for the 4 groups, comparing the initial and final scores at the beginning and the end of the group sessions.

90% of those interviewed claimed they had a residual physical ailment as a result of torture and detention. 5% of these physical ailments were directly attributed to the initial physical insult. 25% expressed dissatisfaction due to their medical complaints being categorized as routine geriatric complaints. 20% were dealing with unresolved family conflict resulting from financial, physical, stigmatization, psychological and emotional trauma that made it impossible to fulfill their occupational social obligations. 85% of the respondents had symptoms of some forms of psychological impairment. 8% of the respondents had some form of suicidal ideation. None of the respondents had previously sought any form of psychological treatment. 73% had sought legal redress and of these, 30% were dissatisfied with the length and complexity of the legal redress process. 80% of respondents cited financial handicaps in their pursuit for legal and medical rehabilitation.

[2] The release of pent-up feelings and repressed emotions after a subject has begun to talk about problems during analysis.

Groups	Physical Symptoms		Anxiety Symptoms		Depression Symptoms		PTSD Symptoms		Behavioral Functioning	
	Before	After	Before	After	Before	After	Before	After	Before	After
Group 1	68%	60%	45%	25%	51.7%	32%	75%	38%	38.9%	33%
Group 2	63%	58%	60%	43%	70%	47%	88%	60%	41%	23%
Group 3	75%	68%	50%	33%	83%	45%	77%	43%	33%	21%
Group 4	48%	35%	70%	45%	68%	40%	73.4%	50%	31%	16%

The group stated that group therapy helped them to 'alleviate the overbearing trauma that had been unattended for 32 years, and gave them a new lease of life, allowing them to begin to heal deep seated wounds. This to them, was the 'justice' that they had hoped for and sought for a long time: a healing from the torture and discrimination they faced and an avenue to tell their story. This information was collected through individual client satisfaction survey forms that sought to answer among other questions whether following the counselling sessions, one gained a better understanding of their problems, whether they felt that the counselor had a good understanding of their problems, whether they felt comfortable talking openly in the sessions, whether the counseling sessions helped them to not only understand but to begin to address their issues, among other questions. Individuals filled in the forms, giving candid feedback based on their own experiences in the group sessions.

This marked improvement in the scores registered by the men demonstrates that the group therapy as indicated in the table above, coupled with the legal and medical assistance which played a key role in aiding the healing process for the survivors of torture. Part of the medical support included but was not limited to medication to alleviate the pain some of the men presented with, prescription glasses for 22 out of the total number supported, as well as physiotherapy for some. However, since the men had already sought legal aid through a private lawyer prior to approaching IMLU for additional assistance, legal aid to this end entailed legal advice, and helping them collate any documentation deemed important in building their case in court. By the end of the group therapy, members reported positive outcomes: trauma healing, marked decrease in isolation, shame, stigma, renegotiations of relationships with family, developing peer relationships, developing intimate wholesome relationships, social action and giving to others, integration back to the community, empowerment and release of self-blame, but ultimately and most importantly, installation of renewed hope and a reason to live and thrive.

***In the words of the victims*:**

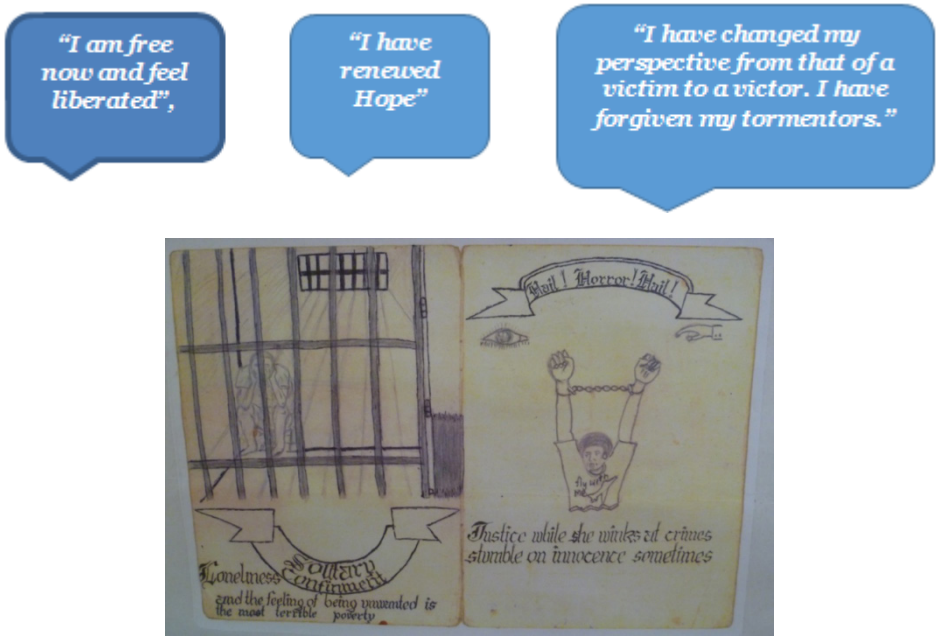

Figure 1. Sample drawing by one of the group members depicting their personal experience

5. Conclusions

IMLU's work on rehabilitation aims to empower the torture victim to resume as full a life as possible. Mostly rebuilding the life of someone whose dignity has been destroyed takes time often times requires different approaches depending on the presenting needs of the victims. Therapeutic work at IMLU has over the years primarily been done with individuals and or their families. However, working with this group of men presented us with a unique opportunity to employ a different approach, for the first time, working with homogenous groups. With an increasing record of clients presenting with similar needs, IMLU undertook the first group therapy approach by working with the former air-force men. The results of the intervention were indicative of an approach that not only addressed individual needs, but reached out to and honed group cohesion among victims who went through torture under similar circumstances-all these done in consultation with the victims, their counterparts who were also peer counselors.

During the course of the therapeutic process, some important lessons emerged:

- A client can be overwhelmed, possibly re-traumatized in the process of healing when the therapy is faster than they can subjectively contain and therefore the counsellor needs to be aware and responsible for managing the intensity of exposure to traumatic materials during the therapeutic process.
- Creative therapies- art/collage, expressive writing and rituals proved to be very effective in allowing the clients to express and process their thoughts and feelings without necessarily having to verbalize the trauma. The creative therapies also provide an environment in which survivors felt much safer to externalize their experiences.
- Rituals and routines especially prayers, beginnings and endings rounds, grief processing rituals, writing letters, burning materials or articles are very effective and efficient in expressing/externalizing the unspeakable and discharging pent-up emotions.
- Psychological and psychosocial support and care accelerates physical healing, this was evidenced on several cases. One of the group member reported that he had stopped taking pain killer and sleep inducing drugs.
- Therapy alone may not constitute exhaustive rehabilitation of all survivors-some may require psychiatric support to deal with the after effects of the traumatic incidents.
- Treatment does not take a linear path.
- It's important to create new meaning as a resolution to existential despair as espoused in the survivor's questions- "Why me?" or even "the existence of existential cruelty"
- During therapy it is common for clients to experience the re-emergence of unacknowledged trauma.

This approach-group therapy- proved to be an effective therapeutic technique. The 4 groups consisted of between 10-14 members each, with some opting out due to unforeseeable circumstances. Participants committed to attending the sessions guided by the counselors and peer counselors. The pairing of the peer counselors proved to be an effective method, which unlocked hitches especially at the start of the sessions. This was especially evident when the men wouldn't open up, and felt that the counselors would not understand their issues, much less have this as an important exercise because for them, talking about their deep seated issues well over 30 years after the ordeal was like opening a can of warms they would rather have kept shut. However, with the peer counselors' input and constant support, and sharing of how that experience was healing and liberating for them, the men in the various groups began to see the importance, and to appreciate the effort by the counselors and their peers in working through those and many other presenting issues in the group therapy sessions. The group participants were provided a platform where they could reveal their innermost thoughts, struggles, anxieties, fear and feelings with their colleagues without fear of being judged. These were men who for many had not seen each other for many years-some even thought their colleagues had died during the coup attempt; for them to see their colleagues, after many years, sharing and catching up on lost time, but most importantly being vulnerable with each other, sharing what and how the torture they were subjected to affected their lives was perhaps the most peace, joy, and affirmation they had ever felt in a long, long time.

One of the best aspects of this group sessions was the ability of the men to re-create very close friendships and comradery that they were used to when they were in the army years ago. Finding this support and discovering that they all went through similar pain, which affected them in more or less the same manner, helped them to support each other in a non-judgmental, supportive and caring manner. For the peer counselors, helping their former colleagues and friends built their self-esteem and belief in their abilities in overcoming their own trauma. In fact, the group of 9 established and registered a non-profit with plans of seeking funding and technical support to reach out to other colleagues in other places in Kenya, but to also keep the group of 56 vibrant, despite their old age.

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REFERENCES

[1] Blanchard, E. B., Hickling, E. J., Forneris, C. A., Taylor, A. E., Buckley, T. C., Loos, W. R., & Jaccard, J. (1997). Prediction of remission of acute posttraumatic stress disorder in motor vehicle accident victims. Journal of Traumatic Stress, 10,215–234

[2] Amris K and Williams A C de C. Chronic pain in survivors of torture. *Pain Clinical Updates, the International Association for the Study of Pain* 2007; XV, Issue 7

[3] Irvin D., with Leszcz, M. (2005). *The Theory and Practice of Group Psychotherapy*- 5th Ed. Basic Books, NY.

[4] Van der Kolk, B. A., & McFarlane, A. C. (1996). The black hole of trauma. In B.A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), Traumatic stress: The overwhelming experience on mind, body, and society (pp. 3-23). New York: Guilford.-Handout prepared by Shanee Stepakoff, based on Herman's book [12], materials provided by Bessel van der Kolk and his colleagues during the certificate training program at the Trauma Center of Boston, and chapter by van der Kolk, van der Hart, and Burbridge "Approaches to the Treatment of PTSD", which originally appeared in S. Hobfoll & M. de Vries (Eds.), Extreme stress and communities: Impact and intervention (NATO Asi Series. Series D, Behavioral and Social Sciences, Vol 80). Norwell, MA: Kluwer Academic.

[5] McFarlane, A. C., & Yehuda, R. (1996). Resilience, vulnerability, and the course of posttraumatic reactions. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), Traumatic stress: The overwhelming experience on mind, body, and society (pp. 155-181). New York: Guilford.

[6] McFarlane, A. C., & de Girolamo, G. (1996). The nature of traumatic stressors and the epidemiology of posttraumatic reactions. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), Traumatic stress: The overwhelming experience on mind, body, and society (pp. 129-154). New York: Guilford.

[7] Keller, A. S., Saul, J. M., & Eisenman, D. P. (1998). Caring for Survivors of torture in an urban, municipal hospital. Journal of Ambulatory Care management, 21, 20-29. -Keller RT. Soldier peer mentoring care and support: Bringing psychological awareness to the front. Military Medicine. 2005; 170(5): 355. Available at: http://kcl.ac.uk/kcmhr/information/publications/articles/stress_ptsd/Keller.Soldierpeermentoring.MilM edMay05.pdf. Accessed on February 9, 2010.

[8] Cunningham, M., & Silove, D. (1993) Principles of Treatment and Service Development for Torture and Trauma Survivors .In: International Handbook of Traumatic stress syndromes. Edited by Wilson, J.P., Raphael, B. New York. Plenum.

[9] Aroche, J, & Marin, L, (1994) 'An Evaluation of a Self Help Group for Latin American Women Survivors of Torture and Trauma.' Ibid.

[10] Schauer, M., Neuner, F., Elbert T. (2011). *Narrative Exposure Therapy: A short Term Treatment for Traumatic Stress Disorders* (2nd edition). Cambridge, MA: Hogrefe Publishing

[11] Friedman MJ: Biological approaches to diagnosis and treatment of post-traumatic stress disorder. 1991. New York Brunner/Mazel

[12] Herman, Judith Lewis (1992). Trauma & Recovery: The Aftermath of Violence. New York: Basic Books