Testimonial Therapy: Impact on social participation and emotional well-being among Indian survivors of torture and organized violence

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Abstract

Introduction: Traumatizing events, such as torture, cause considerable impairments in psycho-social functioning. In developing countries, where torture is often perpetrated, few resources exist for the provision of therapeutic or rehabilitating interventions. The current study investigated the effectiveness of Testimonial Therapy (TT) as a brief psycho-social intervention to ameliorate the distress of Indian survivors of torture and related violence.

Method: Three outcome measures (the WHO-5 Well-Being Scale, Social Participation-Scale and Pain and Anger Analogue) were compared before and after receiving TT, and semi structured interviews were conducted with survivors who had previously received TT.

Findings: Participants showed significant improvements in emotional well-being, social participation, and self-perceived pain and anger. Furthermore, three qualitative interviews with survivors indicated that TT had a positive impact at the community level.

Discussion: Although the study was conducted without a control group for comparison, TT appeared to be an effective method for improving well-being and ameliorating distress among survivors of torture. Furthermore, TT can potentially promote community empowerment. However, more research on this aspect is needed.

Keywords: Torture, trauma, rehabilitation, India

Introduction

Survivors of torture and organized violence (TOV) are prone to several health disorders such as depression, anxiety disorders, substance abuse and chronic pain.[1] Some survivors get by with basic support from their community and families. However, in other cases specialized services are needed to assist survivors in processing the trauma and reengaging in daily life. In many developing countries, torture is perpetrated frequently, and the economic resources for treatment are scarce. Thus the human rights organizations that provide therapeutic assistance often have few staff resources, such as trained psychotherapists or social workers, to provide

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psychosocial and therapeutic interventions for survivors of torture.[2] Testimonial Therapy (TT) may offer a solution to this problem.

TT is a brief human rights based psycho–social intervention for the rehabilitation of torture survivors, which can be used by non-professional counselors in both individual and community settings. TT involves the narration of survivors' traumatic experiences. The trauma story is recorded and jointly edited by a counselor, a note taker and the survivor. The story is then compiled into a document, which is presented to the survivor in a testimony ceremony, during which the survivor is honored in front of his or her community.[3] The document may thereafter, if the survivor agrees, be used for advocacy purposes to raise awareness about human rights violations.

The testimony method was introduced in 1983 by two Chilean therapists, who found that the narration and retelling of traumatic experiences reduced psychological symptoms among political detainees subjected to torture during the military dictatorship in Chile.[4] Since then, the method has been modified and used in a variety of settings and in different political and cultural contexts.[2,5-8] Studies have indicated that TT is effective in bringing a feeling of justice and relief of the psychological symptoms of trauma, as well as contributing to improved emotional well-being and better documentation of human rights abuses.[5,9,10]

In 2008, TT was brought into an Indian context by Danish psychologist Inger Agger in collaboration with DIGNITY - Danish Institute Against Torture and Lenin Raghuvanshi, Peoples Vigilance Committee on Human Rights (PVCHR). A new community-based version of TT was developed, which included an honor ceremony, in which the testimony document is handed to the trauma survivor in a celebratory manner. Furthermore, a manual for conducting TT was developed, as well as a monitoring and evaluation (M&E) schedule to compare well-being before and after the therapy.[3]

PVCHR is a non-governmental organization, which works in 200 villages in Uttar Pradesh and Jharkhand, India to improve conditions and ensure basic human rights for vulnerable groups such as children, women and members of lower castes or the Dalits (untouchables).[i] Through documentation of human rights violations and the provision of legal aid, the organization seeks to create a human rights culture in Indian society based on democratic values. Furthermore, the organization promotes school education and organizational development in villages. Since 2008 PVCHR has adopted TT, and used it in its work as a means of providing psychological and legal support for Indian survivors of TOV. Throughout the years of using TT, PVCHR has created a substantive database by collecting data for M&E as part of the TT process.

With this M&E database as the main foundation, the purpose of this study is to evaluate the effectiveness of TT in improving well-being, social participation and persistent body pain and anger among survivors of TOV in India.

Method

Data collection

The study included 474 Indian survivors of torture and ill treatment. The participants were selected for TT by community workers or human rights activists during their work in

[i] The caste system is a system of social stratification in India. Dalits are outside the system and treated as "untouchables" i.e. not worthy of touching by other castes. Lower casts and Dalits are often victims of social discrimination and violence.[12]

the villages, or among those who had actively sought legal advice from PVCHR. In order to be selected, the participants indicated symptoms of trauma, such as the inability to provide a coherent story.[11]

All participants received TT in the period 2010-2012 and these data were collected at the first session and at follow up one to two months after the last session by community workers. There were 24 participants who did not participate in the follow up session. This was calculated by subtracting the amount of participants who had answered the follow up questionnaire, from the amount who answered the similar questionnaires at the first session.

Additionally, semi-structured interviews were conducted with three male human rights activists who had received TT more than one year before the current study was initiated. The purpose of these interviews was to obtain more detailed knowledge about the testimonial process, and more thorough insight into the different aspects of the effects of TT, which could provide a supplement to the quantitative data. The purpose of the interviews was also to get a preliminary indication of the long-term effects of TT.

Informants were selected from the human rights activists who were working with PVCHR, and had received TT more than a year prior to this study. An interview guide was made, which included questions concerning the participants' experience with both receiving and conducting TT.

Testimonial Therapy

The TT consisted of four sessions, each lasting between 60 to 90 minutes. In the first two sessions the torture survivor, a note taker, and a therapist (interviewer and human rights community worker) sit together to produce a narrative about the human rights violations, which the survivor has suffered. The survivor is encouraged to talk about the traumatic events s/he has experienced, and the note taker records the story and produces a written testimony, which is between two and four pages long.

In the third session a ceremony is held, where the inhabitants of the survivor's village are present; often between 25 and 50 people. During the ceremony, the testimony is read out loud to the audience by the therapist or the survivor. After the presentation of the testimony, the survivor receives a garland to symbolize a transition (rite of passage) from victim to survivor. Hereby the survivor is honored and his or her suffering and testimony is recognized by the community worker, the human rights organization and people in the community.[11]

> *"The community worker honors the survivor and writes the story in the survivor's own words. He creates a good relation with the survivor and a safe environment for the victim to tell his story. It brings relief to the survivor to be able to tell his story. That is also a part of the testimony [process]."*
> Community worker and human rights activist at PVCHR

The ceremony constitutes the turning point in the healing process, by marking the transition from the role of torture *victim*, to an empowered and recognized *survivor* of torture.[3] Previous studies suggest that the ceremony appears to facilitate healing mechanisms such as self-awareness and community support.[3] The fourth session in TT is a follow up session, in which the survivor and community workers meet to re-evaluate the survivor's well-being.[3]

> *"It is a good process to unite everybody [in the ceremony], because the moral level in the*

community becomes so high. During the ceremony I laughed again, and I became aware of my desire to teach everybody [about human rights]."
Survivor

Measures

The following measures were used for the pre- to post intervention outcome comparisons:

1. The *World Health Organization Five Well-Being Index (WHO-5):* WHO-5 consists of five self-report items, which measure emotional well-being, including mood and general interest in daily life activities. The instrument has proven to be a reliable measure for emotional functioning, and can be used as a screening tool for depression.[13,14] Items are rated on a 6 point Likert Scale ranging from 0 (at no time) to 5 (all of the time) and total scores are calculated by adding all item scores and multiplying by 4, leaving a total score ranging from 0 to 100. A total score within 0-35 indicates a high risk of depression, 36-50 moderate risk, and >51 low risk.[15]
2. *Social Participation scale (P-scale):* The P-scale measures restrictions in social participation due to social stigma and physical disability. The 18 items are answered on a numeric scale of 1 (no restriction) to 5 (not able to participate) and severity of participation restriction is calculated as the sum of all items scored, divided into five categories; total score <13 = no restriction, 13-22= mild restriction, 34-53 = severe restriction and >53 extreme restriction.[16] In the current study, item 10, "Do you have the same opportunities as your peers to start or maintain a long-term relationship with a life partner?" was removed as this was not considered suitable in an Indian cultural context.
3. *Pain and Anger Analogues:* The Pain Analogue measures persistent physical pain in the body or head caused by the traumatic event. Similarly, the Anger Analogue measures the intensity of emotional anger about the torture experience. Survivors are asked to rate the level of his/her pain and anger respectively on a 6 point Likert Scale from 0 to 5, where 5 is the highest intensity of pain/anger. The Pain and Anger analogues were developed by PVCHR to indicate the emotional state of mind of the survivor. The Pain and Anger Analogues are iterations of the Numeric Rating Scale for Pain, which has commonly been used in various iterations for people with chronic pain.[17]

At the end of the second session, an assessment of the trauma was undertaken; registering type of injuries, violations, psychological symptoms and the identity of the perpetrators, as well as other interventions that had been received in addition to TT, e.g. medical treatment or legal redress. The psychological symptoms that were registered during the trauma assessment were: Nightmares, flashback memories, fear of going out, self-isolation, panic attacks, anxiety, depression, suicidal thoughts and sleeping problems.

Furthermore, survivors were asked whether they were members of, or worked for a political party, or a human rights organization, and if they believed in human rights. These questions were posed in order to investigate whether the intervention had helped the survivor gain a sense of justice and personal dignity and confidence, acknowledging the principle of human rights, and feeling empowered to help others.

Analysis

Baseline and follow up sum scores from each

outcome measure (WHO-5, P-scale, Pain and Anger Analogue) were compared. Relative changes in the number of participants with risk of depression (WHO-5) and participation restriction (P-scale) and self-reported pain/anger (Pain and Anger Analogue) were calculated. In addition, changes in the number of participants who were politically engaged, e.g. as a member of a human rights organization or as a believer in human rights, were calculated. The effect of TT was represented as the total change from baseline to follow up in each outcome measure. The relationship between socio-demographic characteristics and outcome measures was tested using gamma coefficient

Table 1: *Socio-demographic characteristics*

Variable	Category	N (%)
Sex	Male	253 (53.8)
	Female	217 (46.2)
Age	15-30	157 (33.3)
	31-60	286 (60.7)
	61+	21 (4.5)
Type of victim	Primary	357 (76.0)
	Secondary	113 (24.0)
Caste	Upper	19 (4.1)
	Backward	168 (36.0)
	Scheduled	243 (52.0)
	Tribe	36 (7.7)
	Indigenous	3 (0.2)
Religion	Hindu	398 (84.5)
	Buddhist	14 (3.0)
	Muslim	57 (12.1)
	Christian	2 (2.4)
Education	None	218 (59.7)
	Primary	72 (15.3)
	Secondary	57 (12.1)
	BA	11 (2.3)
	MA	9 (1.9)
	Religious school	1 (0.2)
	Other	36 (7.6)
Occupation	Unemployed	62 (86.8)
	Landless laborer	68 (14.4)
	Household work	177 (37.6)
	Agriculture	53 (11.3)
	Business	8 (1.7)
	Government service	7 (1.5)
	Private service	8 (1.7)
	Other	202 (42.9)

and Chi Square. Each variable with significant relation (P<0.05) to outcome measures at follow up were included as relevant background factors in further analysis. These variables included sex, type of victim, caste, age and religion. In order to further elaborate on the contribution of the relevant background factors to the effect of TT, analysis of variance was conducted; Student's t-test and one-way ANOVA F-test were used to compare equality of means between groups within each variable.

Furthermore, a manual backwards model search, using linear regression, was conducted. The regression analysis was performed according to the hierarchical principle, in which the least significant variable is stepwise removed from the model. The relevant demographic variables as well as *treatments* received prior to TT and *interventions* received in addition to TT were treated as confounders in the regression analysis to investigate whether improvements in outcome measures were associated to these factors.

Results

Participants

The participants consisted of 253 (53.8%) males and 217 (46.2%) females. Age ranged from 15 to 80 years while 75% of the subjects were between 20 to 50 years old. 357 (76%) were primary survivors who had personally experienced a traumatic event and 113 (23%) were secondary survivors i.e. family members of a primary survivor. 95.9% of the subjects were lower caste and the majority (75%) had received only primary or no education. Table 1 presents socio-demographic characteristics of the study population. Table 2 shows the trauma assessment i.e. the number and nature of the human rights violations experienced by the survivors, the amount of psychological symptoms and prior treatment received.

Quantitative outcomes

At follow up, the participants showed great improvements in emotional well-being, physical pain and anger, as well as social participation. The proportion of participants with a high risk of depression decreased from 89.6% at baseline to 30.8% at follow up. In addition, more than 50% of participants displayed no participation restriction at follow up compared to 15% at baseline. Only 1.5% reported extreme participation restriction at follow up compared to 20.8% at baseline. The average score in the Pain Analogue decreased by 70% and the number of survivors reporting no, or low, pain increased from 37.5% at baseline, to 92.4% at follow up. Accordingly, the average score in Anger Analogue decreased by 73%, and the number of survivors who reported no, or low, anger increased from 27.2% at baseline, to 92.4% at follow up. Furthermore, participants who believed in human rights and worked as human rights activists increased from a baseline level of 9.1% and 84.7% respectively, to 21.2% and 92.4% at follow up. Table 3 presents total and average outcome scores at baseline and follow up.

Analysis of variance showed a significant difference between the two genders, with the P-scale (p=0.005) and suggesting that men had benefitted more from TT than women regarding social participation. Furthermore, a statistical significant difference in means was found within different number of treatments received prior to TT (P=0.013), thus indicating that the positive effect of TT on social participation decreased with increasing number of psychological symptoms and increasing number of other treatments, that had been received prior to TT. A significant difference in means was found between groups of interventions received in addition to TT regarding the

Table 2: *Trauma assessment*

	Category	N (%)
Number of human rights violations	0	50 (10.6)
	1-2	171 (36.3)
	3-4	53 (11.3)
	5-6	12 (2.5)
	7-8	6 (1.3)
	9-10	6 (1.3)
Perpetrator	Police	251 (53.3)
	Intelligence service	5 (1.1)
	Armed forces	3 (0.6)
	Paramilitary	1 (0.2)
	Prison official	6 (1.3)
	Private	189 (40.1)
Human rights violation	Physical torture	262 (55.6)
	Sexual torture	79 (17.3)
	Psychological torture	441 (93.6)
	Custodial death	2 (0.2)
Injury	Bruise	67 (14.2)
	Open wound	108 (22.9)
	Burn	9 (1.9)
	Deformity	2 (0.4)
	Fracture	22 (4.7)
	Amputation	4 (0.8)
	Loss of strength	146 (31.0)
	Loss of sensation	96 (20.4)
	Loss of function	193 (41.0)
	Chronic pain	193 (41.0)
	Not injured	98 (20.8)
	Other	1 (0.2)
Number of psychological symptoms	0	3 (0.6)
	1-3	111 (23.6)
	4-6	321 (68.2)
	>6	32 (6.8)
Prior treatment	None	128 (27.2)
	Private hospital	106 (22.5)
	Public hospital	78 (16.6)
	Surgery	5 (1.1)
	Medication	166 (35.2)
	Physiotherapy	2 (0.4)
	Counseling	34 (7.2)
	Legal aid	145 (30.8)
	Testimony before tribunal	6 (1.3)
Other interventions	Medical	86 (18.3)
	Social	306 (65)
	Legal	333 (70.7)
	Community support group	318 (67.5)

Anger Analogue (P=0.006). However this result was not repeated in the regression analysis. Regarding the changes in WHO-5 score and Pain and Anger Analogue no significant difference in means was found with any of the other included variables, indicating that the effect of TT on WHO-5 Well-Being was not confounded by other variables.

Linear regression was then used with each outcome measure in order to control the potential confounders, which had been found in the analysis of variance. These were sex, additional interventions, and prior treatment. Linear regression showed no significant associations with any of these explanatory factors and the effect of TT on WHO-5 Scale and Pain and Anger Analogue or Participation scale.

This indicates that the improvements in the outcome measures reflected the effect of TT only, and not the additional interventions and treatments. PP plot for model control showed that the estimated and expected residuals followed the same distribution and Levene's test showed homogeneity of variances.

Table 3: *Baseline to follow up change*

		Baseline N (%)	**Follow up N (%)**
WHO-5:	Average	14.8	50.2
Risk of stress/ depression	High risk (0-35)	422 (89.6)	145 (30.8)
	Some risk (36-50)	31 (6.6)	80 (17)
	Low risk (>50)	16 (3.4)	219 (46.5)
P-scale:	Average	36.1	13.9
Participation restriction	No	70 (14.9)	253 (53.7)
	Mild	64 (13.6)	88 (18.7)
	Moderate	79 (16.8)	58 (12.3)
	Severe	150 (31.8)	32 (6.8)
	Extreme	98 (20.8)	7 (1.5)
Pain Analogue	Average	3.1	0.94
	No pain (0)	23 (4.9)	146 (32.7)
	Low (1-2)	152 (32.6)	266 (59.7)
	Medium (3-4)	150 (31.6)	32 (7.2)
	High (5)	141 (30.3)	2 (0.4)
Anger Analogue	Average	3.46	0.93
	No anger (0)	16 (3.4)	134 (30.2)
	Low (1-2)	111 (23.8)	284 (63.9)
	Medium (3-4)	163 (34.9)	23 (5.2)
	High (5)	177 (37.9)	3 (0.7)
Human rights activist indicators	Political party member	17 (3.6)	10 (2.1)
	Works in political party	19 (4)	10 (2.1)
	Member of HR movement	43 (9.1)	100 (21.2)
	Believes in HR	399 (84.7)	435 (92.4)

Qualitative outcomes

The three semi-structured interviews further indicated that TT had a positive impact on the distress caused by the torture experience. It was evident that TT has resulted in huge improvements in social and psychological well-being both on an individual level, as well as in the informants' communities.

All three informants stated that talking with others about their traumatizing experiences helped them cope with their distress and sadness and made them feel more self-confident. One informant expressed the following thoughts about the testimony process:[ii]

> *"Before testimony [therapy] victims feel lonely and they do not tell their pain to anybody… But after testimony therapy I [put] outside my pain and share my story to encourage others. It is [a] very good process to give honor in front of [the] community and I feel that I have [got] my own dignity… The victims understand that we are also good citizens of this country; we are not criminal and we are not the most marginalized, we have many people with us. So this is the change; they understand their dignity."*

In addition, the informants explained that after receiving TT, many survivors become human rights activists themselves. In this way, they can help and educate other people in the villages about their rights and possibilities of pursuing and claiming justice, as well as the importance of sharing their problems with others.

> *"[In] the meetings I learn so much and I have spoken to teach other persons… It is very good to me to help any other person to release his torture … [I] wish that I reach out to many people and try to break the silence and [that] they start speaking and they just feel free from the torture and come to a free world.*
>
> *"After [receiving] testimonial therapy I became a human rights activist. I now work in the village to promote human rights awareness by encouraging the villagers to report any incidence of ill-treatment or other problems."*

The people in the villages of the survivors are invited to participate in the testimony ceremonies, and during these ceremonies their fellow villagers experience how the survivors are honored. This helps re-integrate the survivors in the community, but it is also an opportunity for the villagers to learn about human rights. Many are also encouraged to share their own troubles and pursue justice themselves. Through the TT, people of the villages become united, encouraged and *empowered* to help each other change their situation and defend their rights as human beings.

Discussion

Overall, subjects improved in all outcome measures. Improvements were most pronounced with the WHO-5 Well-Being Scale (pre-therapy average: 14.8, post-therapy average: 50.2). However, significant improvements were also evident with the P-scale (pre-therapy average: 36.1, post-therapy average: 13.9), the Pain Analogue (pre-therapy average: 3.1 post-therapy average: 0.94) and the Anger Analogue (pre-therapy average: 3.46, post-therapy average: 0.93).

The quantitative analysis indicated, furthermore, that the effect of TT was not associated with demographic background

[ii] The interviews were conducted with a PVCHR staff member as translator.

factors or other types of intervention, which the survivor had received. Thus, the statistical findings overall suggest that TT is an effective method for rehabilitation of Indian survivors of TOV. The positive impact on the individual level outcomes was supported through qualitative interviews, which also indicated a positive long-term impact.

In addition, the interviews suggested benefits at the community level. The term community empowerment refers to a process in which individuals, groups and local communities work together towards more organized forms of social action, and involve the achievement of increased self-esteem and self-determination.[18,19] Considering the community workers' accounts, it seems likely that community empowerment may be another positive mechanism of the TT ceremony.

There are; however, a number of limitations to this study. A pre-post test design can only be the basis for tentative conclusions about intervention effects. The observed positive effect could have alternative explanations related to the study-design such as social desirability and external events. i.e.. TT is one of the many interventions that PVCHR implements in the villages.

Other than TT, the organization sets up folk-schools, arranges community meetings and assists with legal advocacy. It is therefore difficult to completely isolate the effect of TT since the improvement of the participants' sense of well-being may have been the result of a combination of all these actions. However, with the statistical analysis it was possible to control for some of these additional interventions, as well as prior treatment, and this did not seem to confound the effect of TT. Other methodological problems within this study include missing data from drop-outs. There were 24 participants who did not participate in the follow up session. One possible explanation for this drop-out rate, is that the survivors were feeling better, had already moved on in their lives, and therefore did not wish to participate in the follow up sessions. However, it was not systematically investigated as to why these survivors chose not to participate in the follow up session. Moreover, the drop-out rate of 24 participants is fairly low, and hence we do not believe this had a substantial effect on the results.

Furthermore, the psychometric properties of the measures used in this setting imply there are some limitations to the study. For instance, the P-scale was developed to measure participation restriction in individuals with stigmatizing disabilities caused by leprosy.[16] The use of the P-scale with torture survivors without additional validation is therefore not satisfactory. However, the P-scale was considered appropriate to this study, since many victims of TOV suffer from physical disability and social stigma, which can lead to restrictions in social participation. Back-translation of outcome measures and cultural adaptability should be considered in future studies of TT.

However, with these positive results, this study provides a foundation for further and more comprehensive research. The promising findings imply that there is reason and need for more comprehensive randomized controlled trials (RCTs) in order to demonstrate more definitively the effectiveness of TT.

Ethical considerations have to be taken into account when designing such studies. First of all, an RCT is expensive and may not be appropriate for a setting characterized by limited resources. Furthermore, it may be considered ethically problematic to exclude some victims of torture from the potential beneficial effects of receiving TT. Using waiting-list subjects as a control group may

be an option; however, this will limit the possibilities for long-term follow up.

Through the interviews it was possible to achieve a more detailed insight into the use and effect of TT in an Indian context. The interviews were not exhaustive; however they were useful as a supplement to the quantitative data material. The potential effect of TT at community level would not have been discovered solely using the statistical data.

The mixed method approach in this study was thus helpful in illuminating different aspects of the effect of TT. Furthermore, each method was successful in confirming the results, thereby adding to the validity of the study. More research is needed to clarify the effect of TT at community level. Outcome measures which focus on community empowerment or community mobilization would be interesting to include in future studies of TT.

Conclusion

The current study has added to the evidence of TT as an effective method for reducing psychological distress and increasing well-being and social participation in Indian survivors of TOV. Sharing their trauma story through the testimony process improved the survivors' psychosocial functioning and enabled them to advance on the path to recovery, accepting new responsibilities and regaining satisfactory functioning in their families and environment. Furthermore, it appears that TT has a positive impact at the community level by promoting community empowerment. This study provides the foundation for further research on this aspect, such as controlled trials to determine the effect of TT on individual- and community outcome measures.

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