TRUST Works: Delivering Trauma Recovery Understanding Self-Help Therapy (TRUST) to Refugees from Eritrea

Selam Kidane

Chapter in: Enslaved
Trapped and Trafficked in Digital Black Holes:
Human Trafficking Trajectories to Libya

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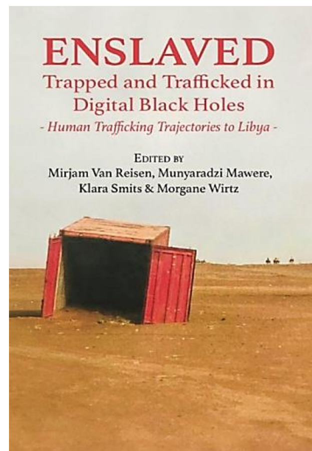

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Chapter 8

TRUST Works: Delivering Trauma Recovery Understanding Self-Help Therapy (TRUST) to Refugees from Eritrea

Selam Kidane[1]

Introduction

> *In the absence of therapeutic support, traumatised refugees fail to grasp the opportunities presented to them and often continue to flee to new destinations, despite the risks involved. There is a need for mental health support to be provided to refugees for them to be able to recover from trauma and function socially and economically. This study found that TRUST – a Trauma Recovery Understanding Self-Help Therapy delivered through smart phones – reduced the symptoms of post-traumatic stress disorder (PTSD) and increased socio-economic resilience among highly-mobile and highly-traumatised communities, such as Eritrean refugees.*

The experiences that push refugees out of their home countries into places of asylum have the potential to be extremely traumatising. Whether it is political violence, extreme state repression, or civil war, the devastative consequences for individuals and communities does not take much imagination to grasp. These periods of upheaval often result in the dislocation of people, who are forced to flee their homes in search of security and prospects (George, 2012). The narratives of all conflicts – be it in Eritrea, Rwanda, Afghanistan, Kosovo, Darfur, or Syria – tell the same story: that the impact of displacement is often far greater than the number killed and injured (Kidane, 2021). In addition, as

[1] The author is grateful Dr Mia Stokmans, who provided technical support and implemented the statistical analysis of the study.

conflicts tend to rage, without viable lasting solutions, the crisis for refugees can drag on for decades, leaving them traumatised and without a permanent home (Salehyan, 2007).

While the link between trauma, conflict and the outflow of refugees is obvious, there is still a gap in our understanding of the implications of trauma for refugees and their long-term prospects and, consequently, trauma support is seldom provided to them. This is despite the fact that the flow of refugees has been on the international agenda for many years (Teitelbaum, 1984). Psychotherapy is often not a priority in the initial stages of a disaster response, with many providers prioritising resources away from psychotherapy, which is considered to be impossible or costly to provide (Gelbach & Davis, 2007).

In the absence of therapeutic support, traumatised refugees fail to grasp opportunities presented to them and often continue to flee to new destinations, despite the risks (Schwarz, 2011). With the aim of exploring the feasibility of delivering cost effective and highly contextualised mental health support to address high levels of trauma in the emergency context of refugee camps, this research looked at the delivery of trauma support to Eritrean refugees in a refugee camp in Ethiopia.

The need for mental health support for Eritrean refugees

High prevalence of PTSD among Eritrean refugees

Eritrean refugees have been making headlines, both because of the sheer number leaving the country, as well as the enormous risks they have been taking in the process. The violence being perpetrated against Eritreans has been recorded in a report by the United Nations (UN) Commission of Inquiry (COI) on Human Rights in Eritrea, which investigated the human rights violations in Eritrea, concluding that these crimes could potentially amount to "crimes against humanity" (UN Human Rights Council, 2015, p. 449). The report called for accountability on behalf of the millions of Eritreans victims and their families who have suffered atrocities at the hands of the Eritrean government, including conscription into indefinite national

service (which includes forced labour) and the systematic use of extrajudicial killing, torture, and rape (UN Human Rights Council, 2015). Against the backdrop of the harrowing violations documented by the report against groups and individuals in Eritrea, it is not difficult to foresee the devastative traumatic impact on victims.

The COI states that the regime of President Isaias Afwerki has perpetrated violations "on a scope and scale seldom witnessed elsewhere" (UN Human Rights Council, 2015, p. 13). In addition, it was found that the government is using extreme surveillance and censorship, creating a culture of fear in order to curb all forms of dissent, even at the level of thought. As a result of this surveillance, Eritreans live in constant fear of detention, arbitrary arrest, disappearance, torture, and even death. This surveillance culture has also resulted in an atmosphere of mistrust and, hence, self-censorship across communities and even within families (UN Human Rights Council, 2015).

The report also highlights that forced conscription into the indefinite national service is trapping an entire generation of men and women, making families destitute as result. This is causing Eritreans, including underage children, to leave the country. Women face additional challenges in national service in the form of gender-based violence: "Sexual violence against women and girls is widespread and indeed notorious in military training camps. […] Furthermore, the enforced domestic service of women and girls who are also sexually abused in these camps amounts to sexual slavery" (UN Human Rights Council, 2015, p. 13). In addition, the report also identified that Eritrean officials frequent use beating and rape as a way to inflict physical and psychological pain, to obtain confessions or information, and to punish, intimidate or coerce detainees and conscripts.

Regarding the mass exodus of Eritreans fleeing their country, the COI report makes it clear that the root cause is inside the country. It states that: "Faced with a seemingly hopeless situation they [Eritreans] feel powerless to change, hundreds of thousands of Eritreans are fleeing their country", despite the fact that "Eritreans who attempt to leave the country are seen as traitors", and that "the

government has implemented a shoot-to-kill policy in border areas to prevent people from fleeing" (UN Human Rights Council, 2015, p. 6).

Many researchers have found that these journeys entail enormous risks and hazards along the various routes to destinations deemed 'safe' (Van Reisen, Estefanos & Rijken, 2012; 2014; Connel, 2012; Hotline for Migrant Workers, 2011). Many of the refugees are young (sometimes minors) and are often avoiding the indefinite national service. They leave either after they have been forcefully recruited or to avoid impending forced conscription (Kibreab, 2009; Van Reisen, Saba & Smits, 2019).

Unfortunately, the predicament of Eritreans has become entrenched, and the impact on the population is enormous. While not everyone in Eritrea has direct experience of imprisonment, torture, sexual exploitation or rape, everyone lives in fear and knows someone in prison or has been tortured, raped or sexually assaulted (Human Rights Watch, 2009; Hepner, 2009). As a result, Eritreans live in a general atmosphere of uncertainty, repression, and hopelessness (Kidane, 2015).

Collective trauma among refugees

In addition to causing post-traumatic stress disorder (PTSD) in individuals, the impact of political violence can also extend to whole communities and society at large in the form of collective trauma. Collective trauma is a condition that refers to population-wide shared injury to the sociocultural context (Saul, 2014). Traumatic experiences, such as the ones faced by Eritreans refugees, can be perceived as collective when they affect several people who have a sense of belonging to one another and when the fearful and painful events they faced have left a mark on their collective awareness and memory (Kidane, 2021). This makes trauma a social construct, impacting not only on the past (or present) identity of survivors, but also on their future identity (Pastor, 2004).

Taking a collective approach in conceptualising trauma is an important element of the contextualisation needed. When

considering trauma healing for refugees, contextualising interventions at the collective level is crucial to account for the fact that, in addition to individual trauma, many of them are also suffering from collective trauma (Kidane & Van Reisen 2017). In addition, the cultures that refugees come from are also sometimes collectivistic (Suh & Lee 2020). This adaptation is as important as the language and cultural contextualisation, and is a distinct departure from the Eurocentric model of PTSD treatment, which focuses on individual trauma and, hence, raises issues about the veracity of these 'universal' psychological interventions, mainly developed in Western contexts (Kidane 2021). Trauma healing should not focus only on addressing individual trauma and symptoms of PTSD, but include the rehabilitation of survivors and processing of collective memories.

Spiralling mental health problems due to unaddressed trauma

The sheer number of people who leave Eritrea has placed the country among the top refugee producing nations in the world. Reports from the United Nations High Commissioner for Refugees (UNHCR) outline that in the first 10 months of 2014, the numbers arriving in Europe nearly tripled, from 13,000 the previous year to 37,000 (UNHCR, 2014). In 2014 and 2015, roughly 40,000 Eritreans made the extremely hazardous Mediterranean crossing to arrive in Italy (Lanni, 2016). In 2014, around 5,000 Eritreans fled their country every month; this is a significant population movement for a small country of 6 million and it earnt Eritrea the title of one of the top generators of refugees (UNHCR, 2014). After Syrians, Eritreans made up the largest group of those entering Europe to seek refuge. In 2016, UNHCR reported that 52,000 people had escaped Eritrea, and by 2018 estimated that about 12% of the total population had been pushed out, many of them escaping indefinite national service (Human Rights Watch, 2018).

These refugees include separated children, vulnerable women with young children, and a vast number of vulnerable young men fleeing to the nearest refugee camp, with some moving further in the region or to Europe. Those who succeed in crossing the Mediterranean Sea have survived dangerous journeys across the inhospitable Sahara

desert and the unpredictable Mediterranean Sea (UNHCR, 2014; Hotline for Migrant Workers, 2011). The number of refugees, as well as the risks they take, have been a cause of concern to many, who keep asking why so many are leaving Eritrea (e.g., BBC, 2015; Kingsley, 2015; O'Brien, 2015; Economist, 2013). In answer, many lament Eritrea's dramatic plummet from being held as a beacon of hope to many (Babu, Babu & Wilson, 2002; Kibreab, 2009), to its current state as the place from where tens of thousands flee, often taking unimaginable risks (Kibreab, 2015). Some note that the "desperate situation" in the refugee camps is contributing to the urge to continue to move, taking the risks they do (Brhane, 2016).

In addition to individual and collective violence (Amnesty International, 2004; Human Rights Watch, 2009), in Eritrea there is extreme political repression and inhumane treatment, including torture perpetrated against ordinary citizens, experiences that are known to pose psychological risks (Modvig & Jaranson, 2004), including traumatic threat to the integrity of the self (Chapman & Gavrin, 1999). Many people exposed to traumatic stress will experience stress responses including avoidance, various forms of sleep disturbances, hyperarousal and hypervigilance and may engage in behaviour akin to anticipation of further risks (Chrousos & Gold, 1992; Tsigos & Chrousos, 2002). Repeated or constant activation of the stress response in the body and brain, known as allostatic load (McEwen, 2003), corresponding to post-traumatic stress, creates a state of fear, hopelessness and even horror in response to the threat of injury or death (Yehuda, 2002). In a recent report, Haynes (2022) confirmed, using Freedom of Information requests, that five unaccompanied asylum-seeking children (UASC) aged 14 to 25 had died by suicide between 2018 and 2022 in the United Kingdom. Four out of the five were a group of friends who were all young men from Eritrea (Taylor 2019). Although there were many indicators of deteriorating mental health in the young men (Haynes, 2022) there is nothing to indicate that they were able to access services that matched their needs, including language and cultural specialism.

Contextualised support

Much of our understanding of conflict-induced migration is focused on the economic consequences, such as poverty, inequality, economic restructuring and pressures on development – and these things are often considered to be the 'root causes' of such migration (Hamilton & Chinchilla, 1991). Failure to develop and deliver effective support to individuals and groups exposed to traumatic stress and with symptoms of PTSD presents a significant constraint on recovery and rehabilitation (Gelbach & Davis, 2007).

In addition to the scarcity of mental health services, there is the additional challenge of contextualising services both historically and socio-culturally to the target population (Stammel, 2019). There is research outlining examples of situations where culturally inappropriate services delivered in emergency contexts had detrimental impacts; for instance, Kosovar survivors of gender-based violence in Albania were subjected to publicly disclosing their predicament, which resulted in honour killings (Wessells, 2009). In another example, during the long history of violence in Sri Lanka, women who participated in therapeutic programmes after losing male relatives were ostracised (Argenti-Pillen, 2013).

The feasibility of providing culturally sensitive and resource effective mental health support to refugees in emergency and disaster contexts (often refugee camps and centres for internally displaced people), and particularly the feasibility of providing trauma support interventions, is, therefore, a pertinent subject that transcends both the service provision and policy development aspects of refugee support. This research focuses on trauma as a defining feature of the experiences of refugees. As mentioned above the devastation entailed in the refugee-producing process, ranging from individual experiences of harassment, persecution, inhumane treatment and torture, as well as collective experiences of terrorising and mass killings, are known to result in persistent symptoms that damage the victim in many ways, including damaging their self-esteem and their trust in others, leading many to experience changes to their very identity (Barudy, 1989). There are studies that indicate a high prevalence of depression and

PTSD in refugee communities, affecting 40 to 70% of the population (Baingana, 2003). This is indicative of how political conflicts and the associated violence that cause refugees to flee their homes can lead to mental illness, with debilitating effects (Silove, Ekblad & Mollica, 2000).

On top of blighting the lives of individual victims, these experiences have implications for the wider community. Collective trauma often results in whole communities succumbing to detrimental maladaptation affecting their long-term wellbeing. A study in Cambodia, found that following the violence of the civil war in the 1960s that led to the devastative Khmer Rouge rule, which decimated the social fabric of the society, there was a high prevalence of psychiatric symptoms among Cambodian refugees, even 10 years after the events (Boehnlein *et al.*, 2004). Similar results were found in a survey of 993 adult participants from the largest Cambodian internally displaced person (IDP) camp on the Thailand-Cambodia border, where 80% of the participants were identified as feeling depressed and were experiencing somatic complaints, despite good access to medical care (Mollica *et al.*, 1999). In a Mayan village in Guatemala it was observed that everyone was experiencing an overwhelming sense of guilt coupled with a host of psychological difficulties comprising fear, depression, loss, abandonment, despair, humiliation, anger and solitude. In addition, many experienced a shattering of their faith in God. The population was subject to a genocidal campaign from 1981 to 1983, which resulted in the massacre of 600 people, mostly by Guatemalan troops. The situation led to people passively retreating to conformity with mistrust, incubating a cycle of vulnerability that continued to threaten recovery long after the events had taken place (Manz, 2002).

Resource limitations

The availability of an adequately trained workforce that is able to deliver therapy in languages that are accessible and with the required awareness of the cultural, social and political contexts is limited. This is so, even in well-resourced setting, and much more so in refugee camps and settlements (Kidane, 2021). The difficulties associated

with delivering appropriate trauma support are not limited to availability and content. Even if there were ample resources and enough will to provide the services that refugees need for processing complex individual and collective trauma, there are additional considerations that might make delivery complicated. For instance, in addition to the content, of trauma processing therapy, considerations should also be given to delivery approaches and the practicalities of 'traditional psychotherapy'.

The delivery of therapy is further complicated by the high mobility of refugee communities, as many individuals and groups might be on the move, either because they have been prevented from settling or because they feel unsafe (their traumatised state of mind can also contribute to feelings of being unsafe). Without accessing support for their trauma, refugees are prone to keep moving in search of safety, while traditional trauma support modalities require them to settle in order to access trauma support. Given these complexities it is not surprising that neither advances in practice, research and policies nor the availability of many theoretical models and approaches have been able to address traumatic stress among refugees; most refugees who experience traumatic difficulties and who, hence, have complex needs for mental health support, never receive the appropriate level of care and provision, as a result of the complexity of their needs and the scarcity of resources for meeting such needs (Silove, Ventevogel & Rees, 2017). Given the number of refugees on the move and their potential levels of trauma, the challenge for society – and particularly for those seeking a more equitable society – is to be able to deliver the much required assistance within the realistic means of society, and to do this effectively.

In recognition of the resourcing difficulties, organisations such as WHO have looked at implementing less resource intensive approaches, such as self-help. WHO has developed a self-help guide, *Self-Help Plus (SH+)*, in an effort to overcome the challenges of finding the number of suitably trained professions required to deliver trauma support to refugees (Epping-Jordan *et al.*, 2016). SH+ is based on the third-wave cognitive behavioural therapy, acceptance and

commitment therapy (ACT), which focuses on enhancing psychological flexibility. This adapted version of ACT was audio recorded over five sessions and is delivered with an accompanying manual. A trial of SH+ with Ugandan refugees in South Sudan found that the intervention was effective in reducing psychological distress (Hayes, Luoma, Bond, Masuda & Lillis, 2006).

SH+ and other self-help guides have the potential to solve the human resources challenge involved in delivering trauma therapy to refugees. However, as outlined above, there are other challenges to be overcome, including the high mobility of the target population and, while it is a useful adaptation, the delivery on (analogue) audio does not make the intervention as mobile as the target communities. Using information and communication technology (ICT) to assist delivery can enable effectiveness under these circumstances. This is a particularly attractive option given the prevalence of smart phones and the fact that Eritrean refugees already use these phones to access useful and trusted information from fellow refugees, as well as official sources such as media outlets (Kidane, 2016).

Research question

Despite the prevalence of PTSD among refugees, we need to exercise caution when drawing conclusions about PTSD in people on the move. We should not assume the presence of PTSD, as there are confounding variables in the chain of events leading to disorders and suicides and vivid and painful memories of the past can fall within the range of normal responses to adverse contexts (Summerfield, 1995; 1996). Nonetheless, we need to be mindful of the evidence linking exposure to conflict and atrocities and symptoms of mental illness including PTSD (Pederson, 2002).

With this in mind, it is also clear that refugees are generally unable to access the level of mental health support they require, either in their first point of refuge (displacements camps and refugee camps across their national borders), or in their 'more secure' final destinations where one would expect more understanding and better resources. This lack of support is a more complex issue than simply resourcing,

it also includes the difficulties associated with understanding the context of trauma and traumatisation that pushes refugees out of their homes. When working with traumatised refugees, the historical context becomes imperative, in addition to lingual and cultural adaptations, which are crucial in contextualising therapeutic approaches (Dixon, Ahles & Marques, 2016; Bass *et al.*, 2013).

Hence, this research looks at the possibility of delivering a self-help tool that allows refugees in low resource settings to address and manage the stress caused by trauma. A programme was developed for the delivery of trauma support to refugees via mobile phones, which have been shown to be a trusted and integral part of the lives of many refugees. As fully outlined in Kidane (2021), this programme consisted of a six-session intervention known as Trauma Recovery Understanding Self-Help Therapy (TRUST), which was designed to overcome the challenges with expertise and logistics inherent in refugee camps. TRUST, which addresses both individual and collective trauma, is simultaneously based on self-help techniques from Eye Movement Desensitisation Reprocessing (EMDR) therapy, an approach that has been particularly effective in the integration of traumatic memories in PTSD (Shapiro, 1989), including among refugees (Mooren, De Jong, Kleber & Ruvic, 2003). In recognition of its effectiveness, the World Health Organization (WHO) has approved EMDR as a top-level evidence-based therapy (WHO, 2013).

This study explored the effectiveness of TRUST in reducing levels of traumatic stress and collective trauma among Eritrean refugees in refugee camps in Tigray, in northern Ethiopia. It addressed the question: *Will a short self-help trauma intervention delivered using ICT have an impact on reducing post-traumatic stress (PTS) and enhancing resilience in the high trauma and low resource contexts of young Eritrean refugees?*[2]

[2] This study has been previously published in Kidane, S. (2021). *Trauma, collective trauma and refugee trajectories in the digital era: Development of the Trauma Recovery Understanding Self-Help Therapy (TRUST).* African Books Collective

Research design

The core consideration of the research conducted between 2017 and 2018 relates to the development and delivery of a trauma intervention that reduces trauma levels (both collective and individual) and enhances the perception of refugees of their social and economic resilience (Kidane, 2021). A shorter version of the Impact of Events Scale (IES-S) that was adapted for the context, the Internet Social Capital Scale (ISCS), and the Social and Economic Resilience Scale (SER) were the tools used to measure trauma, collective trauma and socio-economic resilience. The construction and reliability of these instruments is fully outlined in Kidane 2021. Here it is sufficient to say that all three instruments used were highly reliable.

The conceptual framework (illustrated in Figure 8.1) highlights the relationship between traumatic stress (indicator of individual trauma), social capital (used here to indicate collective trauma) and socio-economic resilience (an indicator of perceptions of social and economic resilience) in the pre- and post-intervention phases. Pre-intervention, all three variables are independent of each other, however, post-trauma intervention levels of trauma become a mediating variable impacting on both social capital (collective trauma) and social and economic resilience, due to changes in self-efficacy as well as agency.

The research design was experimental to establish the effectiveness of an intervention in the real-life context of two refugee camps in the Tigray region of northern Ethiopia. In a real-life context not all variables can be controlled; instead the researchers are responsive to the environment and mindful of the contextual specificities, documenting them meticulously (Shadish, Cook & Campbell, 2002). One such consideration was the fact that there was no control group that received 'no intervention'. This was due to the fact that it was considered unethical to leave a group of people who had been identified as having experienced traumatic events without assistance in an environment in which there is very little other support available. Instead, we had a group that received a short intervention and a group

that received the full intervention. Another example of reactive adaptation was the shift of the delivery platform from an application (app) that required reliable Internet access (24COMS) to delivery via a Bluetooth app (SHAREit), which was more effective in the context and was in fact introduced to the researchers by the refugees, who had been using it to share material among themselves.

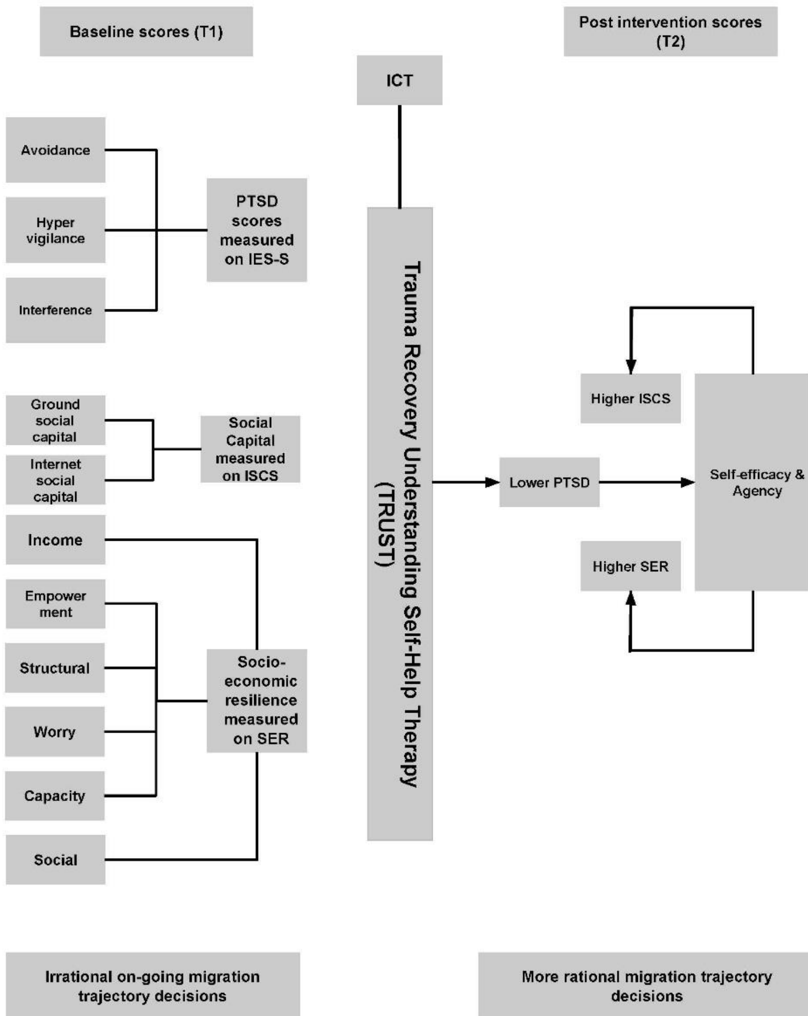

Figure 8.1. Conceptual framework (Kidane, 2021)

Another example concerns the provision of phone cards, which were given to all participants. Initially, phone cards were supposed to be in consideration of the cost of accessing the videos and downloading the app. However, downloads were not always needed, as videos were mostly accessed via the Bluetooth application, nonetheless, we decided to not remove the promised reimbursement. Subsequently the phone cards became an incentive that encouraged participants to maintain engagement.

The TRUST intervention

The TRUST intervention is based on a self-help programme, which is delivered in six steps. The concepts in TRUST were adapted from Shapiro's (2012) self-help book which introduces the understanding, coping and reintegration skills incorporated into TRUST with the addition of collective healing.

The first two sessions of TRUST are focused on providing psychoeducation that enables participants to gain a comprehensive understanding of trauma and its impact on the functioning of the brain. This is followed by three skills sessions to enabled participants to cope better with the symptoms of traumatic stress. The finally session provides reintegration opportunities to enable them to contribute to the addressing trauma in their communities.

TRUST is delivered via ICTs to address the challenges of posed by the high mobility of the target community and the dearth of suitably trained and qualified therapists who speak the language. Each session is facilitated by a video recording from a therapist who briefs and guides participants on the content of the session and demonstrates techniques; the videos are then uploaded onto a platform (like Vimeo or YouTube) that is password locked and only made available to registered participants who have accessed the sessions in the set order. There are also opportunities to send text questions and remarks.

Hypotheses

The effectiveness of the TRUST intervention delivered via ICT was tested by comparing the shorter version (psycho-education

component) of TRUST with the full programme. The hypotheses to be tested were as follows:

Hypothesis 1: In the pre-test we expect to see a negative correlation between post-traumatic stress (measured on IES-Short) and the components of:

- Social and economic resilience (except worriedness, as high values on that scale indicate more worry)
- Social capital (ISCS, scores online and offline)

Hypothesis 2: The full TRUST programme will produce better results than the shorter version (which delivers psycho-education alone), including:

- Reductions in post-traumatic stress
- Increases in the scores of social and economic resilience
- Increases in social capital (both online and offline)

Hypothesis 3: Livelihood support will:

- Decrease levels post-traumatic stress
- Increase social and economic resilience (except worriedness, as high values on that scale indicate more worry)
- Increase the components of social capital (both online and offline)

Participants

For this study, 103 participants were selected using purposive sampling approaches, the selection was based on the research team's intimate understanding of the population and their lives in the camps. Participants were then randomly assigned to receive either the short or a full version of TRUST. As some of the participants also received livelihood support available from charities in the camp, four groups were established: (1) participants who received the short version of TRUST and livelihood support, (2) participants who received the full version of TRUST and livelihood support (3) participants who received just the short version of TRUST, and (4) participants who

received just the full version of TRUST. Table 8.1 outlines the distribution of participants across the four groups.

Table 8.1. Research participants and intervention groups (N=103) (Kidane, 2021)

Intervention	2-videos group	7-videos group	Total
With livelihood support	14	18	32
Without livelihood support	36	35	71
Total	50	53	103

Research instruments

Three psychometric tests were used: Impact of Events Scale (IES), Social and Economic Resilience Scale (SER) and Internet Social Capital Scale, and all three tests were adapted for use in the context, as detailed by Kidane (2021). All three scales had a high degree of internal consistency and were reliable for use in this research.

IES is the one of the most widely used self-reported measure of PTSD. The short self-reporting scale was developed in 1979, as a tool for assessing the degree of symptomatic response to a specific traumatic experience that took place in the previous seven days (Horowitz, Wilner & Alvarez, 1979). To ensure fitness for use with highly mobile communities, it was decided to develop a shorter version (Kidane, 2021). To ensure the validity of this short version, the three constructs of the IES (intrusion, avoidance and hyperarousal) were all included (as suggested by Thoresen *et al.*, 2010). The adapted scale of IES-S was found to have strong consistency as detailed in Table 8.2.

Table 8.2. Mean and standard deviation of IES-Short items

	Mean		Standard deviation	
	Pre-test	Post-test	Pre-test	Post-test
Other things kept making me think about it.	3.583	3.085	1.4985	1.4418
I had waves of strong feelings about it.	3.359	2.936	1.5266	1.4051
I stayed away from reminders of it.	3.825	2.574	1.3535	1.4027
I tried not to talk about it.	3.417	2.649	1.5116	1.4421
I had trouble falling asleep.	2.777	2.521	1.4137	1.4348
I had trouble concentrating.	3.068	2.404	1.5033	1.4242
Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	3.000	2.628	1.5780	1.5861

The Social and Economic Resilience Scale (SER) was developed and initially used in a related, but different research in Uganda (Van Reisen, Stokmans, Nakazibwe, Malole & Vallejo, 2019). For this research adaptations were carried out to ensure effectiveness in the current context (Kidane, 2021). Statistical analysis was carried out to ensure that the test had satisfactory internal consistency as detailed in (kidane2021). A summary of the key statistics for SER are given in Table 8.3.

Table 8.3 Summary of SER-S statistics (Kidane, 2021)

		Number of items included	Mean	Standard deviation	Skewness	Kurtosis
Income	Pre-test	4	2.05	0.98	0.858	-0.123
	Post-test	4	2.16	0.99	0.620	-0.480
Empower-ment	Pre-test	3	3.05	0.88	-0.267	-0.640
	Post-test	3	3.54	1.11	-0.373	-0.905
Trust in the system	Pre-test	3	3.15	0.88	-0.370	-0.403
	Post-test	3	3.64	1.04	-0.502	-0.445
Worried-ness	Pre-test	4	3.53	0.77	-0.344	-0.132
	Post-test	4	3.30	1.05	-0.074	-0.905
Capacity	Pre-test	3	2.93	0.98	-0.215	-0.691
	Post-test	3	3.51	1.21	-0.287	-1.061

The other scale that was used was the Internet Social Capital Scale (ISCS), selected for its dual use of measuring social capital both on the ground and online (Williams, 2006). Measuring social capital was important, as various studies have been consistent in their findings that chronic civil war can deplete social capital (Kawachi &

Subramanian, 2006; Wind & Komproe, 2012) and this has a lot of commonalities with collective trauma. Indeed, loss of social capital has also been used to measure collective trauma (Somasundaram, 2014). Similar to SER and IES, ISCS was also shown to have satisfactory internal consistency for use (Kidane, 2021). Table 8.4 outlines some of these key findings.

Table 8.4. Key statistics of ISCS (online and offline) (Kidane, 2021)

		Number of items	Mean	Standard deviation	Skewedness	Kurtosis
Social capital online	Pre-test	11	2.64	1.01	-0.115	-0.990
	Post-test	11	3.07	1.35	-0.271	-1.261
Social capital offline	Pre-test	11	2.75	0.72	-0.302	-0.357
	Post-test	11	3.30	1.09	-0.303	-0.923

Procedures

Participants were briefed in a joint meeting and then invited to consider and consent explicitly. Before being randomly divided into the two main groups, interviews were carried out to collect demographic details, ascertain the availability of livelihood support, and confirm the presence of traumatic experiences. Each participant was then assisted to complete all three psychometric tests for the baseline pre-test scores. The lead researcher carried out all three assessments with all the participants to ensure consistency and to assess the participants' vulnerabilities and risk.

Research assistants then released videos to participants in accordance with their grouping and interspaced to ensure completion of all tasks for each session.

Six weeks post intervention, participants were invited for a second interview using the same psychometric tests as in the first interview. In addition, participants were invited to group discussions to give

them an opportunity to talk about their experiences and to thank them for their participation.

Results

Correlation between individual traumatic stress, collective trauma, and social and economic resilience in the pre-test

The analysis of the correlation between the individual traumatic stress, collective trauma, and social and economic resilience, and across the data gathered for each of the scales, prior to administering TRUST (pre-test), indicates a negative correlation between post-traumatic stress and all components of social and economic resilience, except worriedness (as expected in the hypothesis) (outlined in Table 8.5). There was also a negative correlation between post-traumatic stress and social capital (an indicator of collective trauma), in particular with social capital on the ground (as opposed to online social capital).

Table 8.5. Correlation between PTSD, SER and ISCS scores

		Correlation	Significance
SER	Income	-0.280**	< 0.01
	Empowerment	-0.343**	< 0.01
	Worriedness	0.487**	< 0.01
	Trust in the system	-0.192	0.052
	Capability	-0.269**	< 0.01
	Social embeddedness	-0.252*	0.010
ISCS	Offline	-0.187	0.058
	Online	-0.068	0.495

The effectiveness of TRUST was examined by comparing the two versions as well as the impact on each of the livelihood support groups using MANOVA (multivariant analysis of variance). The first

and second measurements gave a within factor while the livelihood support category 2x2x2 MANOVA gave us a between factor analysis.

Is TRUST effective at reducing traumatic stress?

The results of the IES-S scores are indicative that post-traumatic stress levels changed between the first and second measurement ($F(1.90) = 64.594$, $p<0.01$). Moreover, the interaction time*TRUST is significant ($F(1.90) = 91.80$, $p<0.01$), indicating that TRUST did bring down the levels of trauma, as measured on the IES-S.

Inspection of the estimated means indicate that those who received seven videos of TRUST (i.e., the full programme) reported less post-traumatic stress during the second measurement, than those who received the shorter version with two videos.

Can TRUST enhance social and economic resilience?

The 2x2x2 repeated-measure MANOVAs were intended to show the impact of TRUST on the various elements of the SER-S (subscales).

On the subscale concerned with 'income', the results show that the perception of income did not change between the first and second measurement ($F(1.91) = 0.358$, $p<0.551$), indicating that that the perception of income did not change during the research. However, interestingly, the interaction time*TRUST is significant ($F(1.91) = 15.084$, $p<0.01$), indicating that there was a difference in the perception of income between the 2-video and the 7-video conditions. The estimated means indicate that those who received seven videos of TRUST reported higher income scores and those who received two videos during the second measurement. There are two possible explanations for this: firstly, the fact that people who received the full version of TRUST had more positive assessment of their prospects and, secondly, the people who received the full version of TRUST also received more phone cards (due to the fact they had to engage for longer) and this was considered as additional income. More interestingly, the interaction between time*livelihood support was not significant ($F(1.91) = 1.112$, $p=0.294$), indicating the fact that livelihood support did not alter the participants' perception of their income. Finally, the (three-way) interaction

time*TRUST*livelihood was not significant ($F(1.91) = 0.842$, $p=0.361$). This indicates that being in receipt of both livelihood support and TRUST does not result in a multiplier effect.

For ‘empowerment’, the results are indicative of the fact that the main effect of time is significant ($F(1.91) = 17.662$, $p<0.01$). This signifies that the scores for empowerment changed during the research period. The interaction time*TRUST is significant ($F(1.91) = 42.344$, $p<0.01$), indicating that there was a difference in the scores for empowerment across the two groups; the (2-video and 7-video). The estimated means show that those who received the full seven videos of TRUST reported higher levels of empowerment than those who received only two videos. Meanwhile, the result for the interaction time*livelihood support is not significant ($F(1.91) = 0.069$, $p=0.793$), neither is the three-way interaction time*TRUST*livelihood ($F(1.91) = 1.921$, $p=0.169$).

The results for the subscale ‘trust in the system’ indicate that the main effect of time is significant ($F (1.91) = 23.480$, $p<0.01$), signifying that the scores for trust in the system changed during the research period. The findings also indicate that during the research period the scores for reliance on the system did not change equally for the 2-video and 7-video conditions. The estimated means indicate that those who received seven videos of TRUST reported higher scores for trust in the system. The two-way interaction time*livelihood support and the three-way interaction time*TRUST*livelihood are not significant ($F(1.91) = 1.983$, $p=0.162$; $F(1.91) = 0.311$, $p=0.579$, respectively).

Similar to the above, for the subscale ‘worriedness’, the results indicate that the main effect of time is significant ($F(1.91) = 5.090$, $p=0.026$); hence, overall, the scores for worriedness changed during the research. The interaction time*TRUST is significant ($F(1.91) = 13.438$, $p<0.01$), indicating that the scores for worriedness did not change equally for the 2-video and 7-video conditions. The estimated means show that those in receipt of seven videos of TRUST reported less worry. The two-way interaction time*livelihood support and the three-way interaction time*TRUST*livelihood are not significant ($F(1.91) = 0.368$, $p=0.545$; $F(1.91) = 0.644$, $p=0.424$, respectively).

For the subscale ‘capability’, the results indicate that the main effect of time is significant ($F(1.91) = 21.708$, $p<0.01$). These findings indicate that, overall, the scores for capability changed during the research period. Moreover, the interaction time*TRUST is significant ($F(1.91) = 69.565$, $p<0.01$), indicating that the scores for capability did not change equally for the 2-video and 7-video conditions. Similar to the rest of the scores, the estimated means indicate that those who received all seven TRUST videos reported higher capability. Once again, the two-way interaction time*livelihood support and the three-way interaction time*TRUST*livelihood are not significant ($F(1.91) = 0.644$, $p=0.424$; $F(1.91) = 0.644$, $p=0.424$, respectively).

Finally, for the subscale ‘social embeddedness’, the results indicate that the main effect of time is significant ($F(1.91) = 9.105$, $p<0.01$). This indicates that, overall, the scores for social embeddedness changed during the research. In addition, the interaction time*TRUST is significant ($F(1.91) = 22.474$, $p<0.01$), which indicates that the scores for social embeddedness did not change equally for the 2-video and 7-video conditions. The estimated means indicate that those who received the full seven video version of TRUST reported higher social scores. As with the other scores, the two-way interaction time*livelihood support and the three-way interaction time*TRUST*livelihood are not significant ($F(1.91) = 0.808$, $p=0.371$; $F(1.91) = 0.091$, $p=0.763$, respectively).

Across the board, it seems that livelihood support, which was expected to result in better outcomes for those who were in receipt of the TRUST intervention, did not result in significant differences for any of the SER scores, showing no significant differences in participants’ perceptions of their social and economic resilience. Significantly, the estimated means show that those who were in receipt of the full seven videos of TRUST reported positive outcomes on all components of the social and economic resilience scale after completion of the programme.

Can TRUST improve social capital (reduce collective trauma)? As mentioned above, social capital scores on ISCS were used to indicate levels of collective trauma. The 2x2x2 repeated measure MANOVA analysis indicates that the main effect of time was significant, and this was the case for both the online and offline contexts. TRUST was indicated to have the effect of enhancing social capital scores (therefore, reducing collective trauma), both inside the refugee camps and across the online networks that participants accessed.

For online social capital scores, the results were indicative of a significant main effect of time ($F(1.90) = 14.859$, $p<0.01$), social capital online changed during the research period. However, while the interaction time*TRUST was significant ($F(1.90) = 32.203$, $p<0.01$), the change in social capital online was not equal for the 2-video and 7-video conditions. The estimated means indicate that those in receipt of the full seven videos of TRUST reported higher social capital scores. Similar to the other scores the results for the interactions time*livelihood support and time*TRUST*livelihood were not significant ($F(1.90) = 0.675$, $p=0.413$; $F(1.90) = 2.719$, $p=0.103$, respectively), indicating that livelihood support does not seem to have any impact on social capital, as measured on ISCS.

For offline (on the grounds in the camps) social capital, the results here also show a significant main effect of time ($F(1.90) = 55.409$, $p<0.01$) and, hence, overall, social capital offline changed during the research period. The interaction time*TRUST is significant ($F(1.90) = 82.733$, $p<0.01$), indicating that during the research period change in social capital offline was not equal for the 2-video and 7-video conditions, with those who received seven videos reporting higher social capital offline. In addition, the results for the interactions time*livelihood support and time*TRUST*livelihood are not significant ($F(1.90) = 0.359$, $p=0.551$; $F(1.91) = 1.109$, $p=0.295$, respectively).

Table 8.6 gives a summary of the effect of TRUST on traumatic stress (IES-Short), the various elements of social and economic resilience (SER), and social capital (ISCS). The partial eta-square results can be

interpreted as the percentage of variance in the change between the first (pre-TRUST) and second (post-TRUST) measurement, plus the associated error variance (Pierce, Block & Aguinis, 2004). From these results it can be said that TRUST has a particularly strong effect on post-traumatic stress, capability (on the SER), and social capital offline (ISCS) and, hence, we can conclude that TRUST reduced trauma and enhanced participants' perceptions of their capability (self-efficacy and agency) and social capital.

Table 8.6. Summary of results for the effect of TRUST

		F value	Partial eta-square
IES-Short		F(1.90) = 91.80, p < 0.01	**0.505**
SER	Income	F(1.91) = 15.084, p < 0.01	0.142
	Empowerment	F(1.91) = 42.344, p < 0.01	0.318
	Worriedness	F(1.91) = 13.438, p < 0.01	0.129
	System	F(1.91) = 38.632, p < 0.01	0.298
	Capability	F(1.91) = 69.565, p < 0.01	**0.433**
	Social embeddedness	F(1.91) = 22.474, p < 0.01	0.198
Social capital (ISCS)	Offline	F(1.90) = 82.733, p < 0.01	**0.479**
	Online	F(1.90) = 32.203, p < 0.01	0.264

Discussion and conclusion

The main aim of this research was to see if TRUST, a short-self-help trauma intervention, could be delivered effectively using ICT – having an impact on reducing post-traumatic stress and enhancing resilience – in highly-mobile and highly-traumatised communities, such as Eritrean refugees living in impoverished refugee camps where there is little support available. In addition, we also wanted to see if the different components of TRUST (i.e., the psycho-education

alone, as compared to the full version) could be delivered to the same effect of lowering trauma levels and enhancing social and economic resilience, as well as social capital (reduction of collective trauma).

Clearly, despite the short length of TRUST as an intervention (especially when considering the complex nature of the traumatic experiences detailed), as well as the complexities associated with delivering effective therapy through ICT, the results do indicate lower levels of traumatic stress with the associated benefits of enhanced social and economic resilience and lower levels of collective trauma indicators. This indicates that treating PTSD has positive impacts on mental health, perceptions of social and economic status, and community-wide relationships (social capital). Managing the symptoms of traumatic stress, through a self-help therapy seems to have enhanced participants' self-efficacy in coping. This is the "core belief that one has the power to produce desired effects by one's actions" and "plays a key role in stress reactions and quality of coping in threatening situations" (Benight & Bandura, 2004, p. 113). As individuals with low self-efficacy perceive challenges as dangerous and full of risk of failure, enhancing self-efficacy through self-help can be a significant component in building resilience to trauma (Bandura, 1997) – which seems to be the key achievement of TRUST. The approach used focused on helping survivors of atrocities with extremely traumatic experiences to gain an understanding of their symptoms and then learn some basic skills to enable them to cope with symptoms resulting from these experiences. TRUST also enabled participants to reconnect better with their communities, as resourceful members with high self-efficacy and a new set of key knowledge, understanding and skills that can help them and their communities.

The research also found that, the full 7-video intervention was more effective than the 2-video psycho-education session. TRUST is a three-phased intervention, the first two videos, received by every participant, incorporated only the phase concerned with educating participants about trauma and its impacts. The remaining two phases are contained in the subsequent five videos; these videos resourced

participants to cope with their symptoms, followed by the reintegration phase of equipping them with everyday skills for good quality interactions within their community. The full intervention was consistently shown to be better at reducing PTSD and bringing about associated improvements in SER and social capital (ISCS). Much of the traumatic stress in the camps can be described as complex, it occurred due to prolonged exposure to highly traumatic events of political violence that were perpetrated throughout the lives of the participants. Literature on trauma treatment is fairly consistent on the efficacy of the phase-oriented approach taken in developing TRUST for treating complex trauma (Briere & Scott, 2006; Brown, Scheflin & Hammond, 1998; Courtois, Ford & Cloitre, 2009; Ford, Courtois, Steele, Van der Hart & Nijenhuis, 2005; Van der Hart, Nijenhuis & Steele, 2006).

It was rather surprising that, neither trauma levels, nor the associated benefits of enhanced social and economic wellbeing, or social capital were affected by the availability or otherwise of the kind of livelihood support that was available in the camps. This is surprising in light of the link between resources and trauma. The conservation of resource (COR) theory (Hobfoll, 1989) states individuals strive to garner, retain and protect their resources. Furthermore, the theory predicts that stress will occur following loss of resources, threat of resources loss, or indeed failure or obstruction to gain resources following a significant resource investment. Post disaster studies have found resource loss to be a key predictor of psychological distress (Benight, Swift, Sanger, Smith & Zeppelin, 1999). Studies of conflict and disaster also support the conservation of resource theory assertion that resource loss is likely to contribute to longer-term cycles of loss that hamper recovery (King, King, Foy, Keane & Fairbank, 1999; Kaniasty & Norris, 1995). However in the case of the participants of this study, livelihood support did not seem to be impacted on, as expected. This might be related to the extremely limited nature of the support available in the camps, leading participants to not perceive it as contributing to their resilience/prospects. There were also issues related to the process in which support was provided, which does not take the situation of refugees into account (NGOs often tend to select

the most destitute refugees and focus on supporting those individuals, rather than empowering whole communities to share and manage resources, thereby supporting the most vulnerable holistically). The lack of understanding of the level of support required by those considered most vulnerable (including mental health support) ultimately works against the collective by introducing selection and targeting of the very limited resources to very few members (selected for their vulnerability, inadvertently incentivising ongoing vulnerability), leaving individuals without the support of others, and the community without crucial agency to support its most vulnerable. Where trauma and collective trauma are issues of concern, livelihood support needs to be provided in a way that includes meeting the mental health needs of refugees and their communities.

Having said all of this, delivering TRUST was not without its challenges, and the main challenge concerned the infrastructure for delivering therapy via ICT. The lack of Internet connectivity curtailed delivery as initially envisaged and created a situation in which participants felt alone and were at risk of losing motivation at crucial points of the process (Kidane 2021). This is a serious matter that warrants closer attention for anyone interested in delivering therapy via ICTs in places where connectivity cannot be guaranteed.

The results of this study fully attest to the psychosocial improvements due to TRUST, a carefully contextualised, self-help therapy designed to be delivered in low human and financial resources settings, such as refugee camps and similar settings. However, given that one of the most significant adaptations was to deliver the therapy with the assistance of ICTs, and given the challenges experienced due to the lack of reliable connectivity, it is important that future research focuses on the implications of not having connectivity and, hence, the loss of interactive support and coaching while addressing highly traumatic memories through self-help techniques.

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Ethical clearance

Ethical clearance for this research was obtained from Tilburg University REC2017/16; REDC # 2020n13; REDC# 2020/01 3a; REDC 2020.139.

Author contributions

Selam Kidane is the sole author of this chapter.

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