Group cognitive processing therapy: A specialized mental health intervention that supports improvements in well-being for sexual violence survivors
Context: South Kivu

- Conflict
- Culture of gender inequality
- Pervasive sexual violence
- Consequences
  - **Social** rejection and stigma
  - **Mental health** problems
  - Lack of access to **income**
Academic-NGO Partnership: JHU and IRC

- IRC currently implementing programs to prevent and respond to violence against women in 19 countries
- JHU-IRC collaboration in DRC began in 2005
  - Initial qualitative investigation of mental health and psychosocial needs in one area
  - Led to improved training and monitoring of general psychosocial program with local NGOs
Current Project: Overall Objective and Aims

To identify cost effective and scalable interventions that demonstrate improvements in the psychological, social, and economic functioning of survivors of sexual violence living in Eastern DRC:

- What is the impact of a mental health intervention on social, psychological, and economic functioning?
- What is the impact of a socio-economic intervention on social, psychological, and economic functioning?
Formative Research Phase

1. Qualitative studies in 3 study communities
   ✤ Identify mental health problems relevant to local context
   ✤ Identify tasks and activities that define functionality in these communities
   ✤ Inform selection of interventions

2. Instrument development/adaptation and validation
Intervention Selection: Cognitive Processing Therapy

- Evidence-based trauma therapy
- Structured groups (6-8 women per group)
- Weekly meetings for 12 weeks
- Participation and homework
- Adapted, Trained and Supervised by collaborators at University of Washington (Kaysen/Griffith)
Apprenticeship Model*

- In person training: 2 weeks
- Practice Groups and Piloting of Intervention: 12 weeks
- Intervention Implementation with study Participants: 16 weeks
- Service continuation by trained PSAs

Weekly Supervision (ongoing training)

Supervision as needed

SUPERVISION MODEL

Monitoring quality

Continuous intervention development

Continuous Training

Trainers

Supervisors

Counselors

Clients
April 2010: Needs Assessment

November 2010: Sites selected and randomized

Feb-March 2011: Eligible women identified and Baseline

May-July 2011: CPT and IS implemented

Aug 2011: Qualitative data collection

Sept 2011: Quant Data Collection (1st follow-up)

Feb-March 2012: Quant Data Collection (2nd follow up)
Study Conditions

- **Cognitive Processing Therapy (CPT)**
  - CPT training and piloting conducted in Jan/Feb 2012
  - Provided in 3 concurrent groups of 6-8 women

- **Individual Support (IS)**
  - Continuation of standard PSA program
  - Active listening, counseling, family mediation, stress management, and referral to other essential services
  - Provided as needed and as requested by women
Study Participants

✧ Inclusion Criteria:
✧ 18 years or older
✧ Reporting personally experiencing or witnessing sexual violence
✧ Total symptom score of at least 55 (i.e. average score of 1 for each of 55 symptoms)
✧ Total functional impairment score of at least 10 (i.e. some dysfunction on at least half of the tasks)

✧ Exclusion Criteria:
✧ Suicidality judged by clinical staff to require immediate treatment.
Study Instrument

A wide range of signs and symptoms through adapted versions of:

🔹 A combined mental health assessment (55 items)
🔹 Hopkins Symptom Checklist (HSCL-25) Depression and Anxiety subscales
🔹 Harvard Trauma Questionnaire – PTSD Symptom Section
🔹 Locally identified signs and symptoms
🔹 Function as assessed by tasks of daily living (20 items)
🔹 Trauma experiences (6 items) and coping and service usage section (13 questions)
🔹 Networks and social relationships section (17 questions)
🔹 Extensive economic section
Example Mental Health and Function Questions

For each symptom say: For the problem ______ In the last 4 weeks, how often have you experienced it.

<table>
<thead>
<tr>
<th>Problems</th>
<th>not at all</th>
<th>a little bit</th>
<th>moderate amnt:</th>
<th>a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>B01. Feeling low in energy, slowed down (H)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>B02. Blaming self for things (H,Q)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>B03. Crying easily (H,Q)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>B04. Loss of sexual interest or pleasure (H)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>B05. Poor appetite (H,Q,D)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For each task/activity say:

<table>
<thead>
<tr>
<th>tâches/activités tasks/activities</th>
<th>None</th>
<th>Little</th>
<th>moderate amount</th>
<th>a lot</th>
<th>often cannot do</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>A01. cultivating/farming</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>A02. trading or other ways of making money</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>A03. Cooking</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>A04. looking after children</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>
Difficulty in daily functioning **score** =
The **average** of responses for 20 daily tasks and activities.
# Baseline Characteristics

<table>
<thead>
<tr>
<th></th>
<th>CPT N=157</th>
<th>IS N=248</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years, mean (sd)</td>
<td>36.9 (13.4)</td>
<td>33.8 (12.4)</td>
</tr>
<tr>
<td>Years of education completed, mean (sd)</td>
<td>1.8 (2.8)</td>
<td>2.3 (3.1)</td>
</tr>
<tr>
<td>Number of people living in home, mean (sd)</td>
<td>7.4 (3.2)</td>
<td>6.8 (3.3)</td>
</tr>
<tr>
<td>Number of children responsible for, mean (sd)</td>
<td>4.0 (2.7)</td>
<td>4.1 (2.8)</td>
</tr>
<tr>
<td>Current marital status, No. (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single, never married</td>
<td>20 (12.7)</td>
<td>35 (14.1)</td>
</tr>
<tr>
<td>Married</td>
<td>93 (59.2)</td>
<td>107 (43.2)</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>20 (12.7)</td>
<td>54 (21.8)</td>
</tr>
<tr>
<td>Widowed</td>
<td>24 (15.3)</td>
<td>52 (21.0)</td>
</tr>
<tr>
<td>Ave. HSCL-25 scores, mean (SD)</td>
<td>1.97 (0.5)</td>
<td>2.20 (0.5)</td>
</tr>
<tr>
<td>Ave. HTQ scores, mean (SD)</td>
<td>1.84 (0.6)</td>
<td>2.20 (0.5)</td>
</tr>
<tr>
<td>Ave. function impairment scores, mean (SD)</td>
<td>1.65 (0.7)</td>
<td>1.77 (0.9)</td>
</tr>
</tbody>
</table>
Intervention impact on mental health symptoms

**HSCL-25 Depression/Anxiety Symptoms**

**HTQ Posttraumatic Stress Symptoms**
Both interventions led to remission but CPT was significantly more likely to result in remission of diagnoses.
Intervention Impact on Daily Functioning Outcomes

Average scores for difficulty in completing 20 daily tasks and activities
Other Outcomes

✦ Social Functioning:
   ✦ Small to medium effects on increased group membership and participation and emotional support seeking at post-intervention
   ✦ No intervention effects for size of support networks

✦ Economic functioning:
   ✦ Preliminary analysis shows CPT groups worked approximately 8 more hours per week and reported higher per capita food expenditures than women in the individual support villages
Research Challenges and Limitations

- Baseline differences across treatment arms
- Challenges with instrument validation process and results
  - Inability to generate diagnostic categorization based on locally relevant information
- Differences in supervision intensity and structure across treatment arms
- Challenges in accurately following-up with beneficiaries
Implementation Challenges

- Human and financial costs of implementing a new program
- Start up required dependence on external technical Mental Health professionals
- Security challenges
- Managing expectations of beneficiaries
Conclusions

- Well supervised Group CPT is an effective addition to case management for treating high levels of depression, anxiety, PTSD and dysfunction among sexual violence survivors compared with IS.

- Task Sharing is feasible when supervision structures are in place:
  - Community-based paraprofessionals can provide interventions normally requiring experts when appropriate supervision is provided
  - Interventions in conflict/crisis can work
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  ✦ Programme de Secours pour les Vulnérables et Sinistrés (PSVS)
  ✦ Union pour l’Émancipation de la Femme Autochtone (UEFA)

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  ✦ USAID Victims of Torture Fund and World Bank
Theory of Change 2: Mental Health (Cognitive Processing Therapy), IRC + JHU

- Women participate in group cognitive processing therapy (CPT)
- Women have access to a support network
- Women learn to decrease avoidance and techniques to decrease extreme thoughts
- Women have positive interactions with other women
- Women decrease extreme emotions
- Women feel less stigmatized and decrease avoidance
- Women’s psychological well-being improved (= decreased symptoms)
- Women’s social functioning improved
- Women recover and heal from sexual violence
- Women’s economic functioning improved (= increased income & consumption)