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Abstract

Purpose: Cognitive behavioral (CB) group therapy is an effective therapeutic intervention to treat war-related trauma. The aim of this pilot study was to describe the effects of conducting CB group therapy in a civilian population exposed to war in southern Lebanon. **Method:** Participants presenting with psychiatric symptoms attended an 8-week CB group therapy intervention adapted to the Lebanese culture. Observations from therapists' field notes were reviewed and grouped into commonalities. **Findings:** A majority of the total participants ($N = 10$) reported satisfaction with the CB therapy and a decrease in symptoms. Field notes revealed positive group interactions (i.e., sharing information, cohesiveness), therapeutic benefits (i.e., symptom identification, destigmatizing mental illness, learning coping strategies), and barriers to attendance (i.e., stigma, personal constraints). **Conclusion and Implications:** CB group therapy is a promising intervention for civilian survivors of war trauma. Challenges to conducting such interventions in a war-conflict area are discussed. Future research and intervention planning should address challenges faced during this study to better meet mental health needs.

Keywords

psychiatric/mental health, transcultural health, community health, cognitive-behavioral group therapy, war-related trauma, PTSD, psychiatric morbidity, Lebanon

Exposure to war-related traumatic events greatly affects psychological health (Akinsulure-Smith, 2009; Eytan, Gex-Fabry, Toscani, Deroo, & Bovier, 2004; Farhood & Dimassi, 2012; Lopes Cardozo, Kaiser, Gotway, & Agani, 2003; Priebe et al., 2010). Individuals with untreated trauma-related disorders can experience worsening of symptoms, substance use, or suicidality (Momartin, Silove, Manicavasagar, & Steel, 2003; Rosner, Powell, & Butollo, 2003). According to the World Health Organization (WHO) World Mental Health (WMH) survey assessment of mental health services, lack of resources, lack of psychoeducation, and stigmatization were associated with unmet mental health needs in 17 developed and developing countries (Wang et al., 2007; WHO, 2004). As few as 0.1% to 1% of the surveyed samples used mental health services in low- and middle-income countries such as Nigeria and Lebanon (Wang et al., 2007). Such surveys highlight the need for mental health interventions specifically in areas stricken by conflict where residents suffer high prevalence rates of psychiatric disorders.

The country of Lebanon has been under continuous conflict and instability for more than 3 decades, including a 15-year civil war (1975-1990) and a 20-year occupation in the south. In July 2006, the country was once again engulfed in a devastating war that lasted for 34 days (United Nations

Interim Force in Lebanon, 2006). Civilians residing in the south of Lebanon continue to be exposed to traumatic events, which may cause a cumulative effect in trauma, thus increasing the risk of developing posttraumatic stress disorder (PTSD) and comorbid disorders (Eytan et al., 2004; Johnson & Thomson, 2008). Studies assessing mental health in the south of Lebanon have shown a high prevalence of PTSD and psychiatric morbidity in the general population. Farhood, Dimassi, and Lehtinen (2006) found prevalence rates of PTSD of 29.3% and a mean total General Health Questionnaire (GHQ) score of 10.46 (cutoff score is 5), with a significantly high score on the Severe Depression subscale 5 years after a 20-year occupation. Farhood and Dimassi (2012) also found PTSD prevalence rates ranging from 17.6% to 33.3% and depression rates of 9.2% to 19.7% in civilians residing in the south of Lebanon. In both studies, exposure to war-related traumatic events was strongly associated with both PTSD and depression.

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Although civilian populations exposed to war trauma greatly suffer subsequent mental health disorders, treatments for trauma-related illnesses in certain areas of the world are not accessible to the general population or are nonexistent (Johnson & Thomson, 2008). Individuals who reside in areas of conflict and instability are subjected to continuous traumas such as daily stressors that occur during and after war (i.e., social and material resource loss) (Farhood et al., 1993; Miller & Rasmussen, 2010). Additionally, psychological problems associated with exposure to war and war-related events are compounded by lack of mental health literacy and access to mental health care. Although social support provides some protective factor against mental illness (Farhood, 1999; Farhood & Dimassi, 2012), sociocultural influences within some communities may portray mental illness negatively, which in turn prevents individuals from seeking mental health treatment (Sayed, 2003; Wang et al., 2007). Therapeutic interventions that target both psychoeducation and psychosocial skill building in a safe group environment may be effective in meeting the mental health and psychosocial needs of civilian survivors of war suffering from trauma-related disorders.

Research has shown that cognitive behavioral (CB) group therapy is an effective therapeutic approach for the treatment of trauma-related disorders (e.g., PTSD and depression) (Bisson et al., 2007; Foy & Larson, 2006; Monson et al., 2006). A Cochrane review of psychological treatments for PTSD reported trauma-focused CB therapy to be superior to other methods in terms of its effectiveness (Bisson & Andrew, 2009). Khoo, Dent, and Oei (2011) tested a 6-week CB group intervention with 496 Australian combat veterans. Significant improvement was found after a 12-month follow-up for several outcome measures including PTSD, depression, and anxiety symptoms. CB group therapy has also been successfully used with adolescent refugees in the UK, with a significant posttreatment decrease in PTSD symptoms and behavioral and psychological difficulty in comparison with the control group (Ehnholt, Smith, & Yule, 2005).

Psychoeducation, cognitive interventions, and relaxation training are used in CB group therapy as effective tools in treating trauma (Beck & Coffey, 2005; Foy & Larson, 2006). For example, Akinsulure-Smith (2009) administered a psychoeducational group intervention to refugee and asylum-seeking youth within a New York school setting. Using emotional and behavioral stabilization, trauma education, and stress management, the intervention promoted coping skills, relaxation techniques, and social support.

In people affected by war, group interventions provide a safe environment where shared experience, universality, and social support act as therapeutic factors (Akinsulure-Smith, 2009; Beck, Coffey, Foy, Keane, & Blanchard, 2009; Beck & Coffey, 2005). As opposed to individual therapy, group therapy offers cost-effective psychiatric care with minimal clinician time (Beck et al., 2009; Beck & Coffey, 2005; Bolton et al., 2004), which may be beneficial in developing

countries with little mental health structure. For civilians residing in conflict regions with high rates of war-related mental illnesses and limited access to treatment, CB group therapy can offer an effective intervention with additional therapeutic elements inherent to the group format.

Studies have shown high prevalence rates of PTSD, depression, and psychiatric symptoms in the south of Lebanon due to exposure to traumatic war-related events (Farhood & Dimassi, 2012; Farhood et al., 2006) and severely unmet mental health needs (Karam et al., 2006; Wang et al., 2007). This article describes a pilot study aiming at (1) conducting a CB group intervention with civilians exposed to war trauma and (2) evaluating its effectiveness in improving mental health.

Method

Design and Sample

A randomized control design was initially planned for the current study in which participants of four towns in southern Lebanon were to be randomly assigned to an intervention group or a waitlist control group to receive the same intervention at a later stage. However, due to the small number of participants agreeing to participate, only one group was formed. The design was therefore modified to conducting trauma-focused CB group therapy with those agreeing to participate.

The sample was obtained from a data set collected in southern Lebanon that assessed mental health in the civilian population 1 year after the July 2006 war. For the sampling procedure, see Farhood and Dimassi (2012). Individuals who had presented with high rates of either PTSD or depression as assessed by the Harvard Trauma Questionnaire (HTQ) and Beck Depression Inventory (BDI) were asked to take part in the current intervention. Inclusion criteria were defined by cutoff scores of 2.5 and above on the HTQ (Mollica et al., 1992) and/or scores 9 and above on the BDI (Beck, Steer, & Carbin, 1988). Participants with severe cognitive impairment or psychotic or addiction disorders were excluded.

Eighty-six individuals were identified as eligible for participation. Individuals were contacted by the investigators to discuss the study aims, intervention format, topics, and duration of the study. Twenty-two participants had invalid phone numbers, and 50 refused to participate due to lack of time, changing residence, sickness, personal commitments, or (most commonly) stigma associated with mental health interventions. Fourteen individuals agreed to attend and were contacted weekly regarding date and time of each session.

The study received institutional ethical approval from the sponsoring university, and written informed consent was obtained. In the event psychiatric treatment was required or requested by participants, therapists were instructed to refer individuals to specialized mental health services.

Intervention

The therapists conducting the CB group sessions were two trained senior graduate students in psychiatric mental health nursing from the American University of Beirut. The therapists were unknown to the participants. The intervention was conducted at a Red Cross center located in one of the towns in the south of Lebanon.

The planned format for the CB group therapy consisted of eight weekly sessions focusing on the following:

Week 1: Psychoeducation about trauma and its impact (the CB therapy triangle)

Week 2: Cognitive restructuring/role of cognition in changing emotions and behaviors

Weeks 3 and 4: Affective and narrative expressions of trauma and loss

Week 5: Processing the traumatic experience

Weeks 6 and 7: Relaxation training

Week 8: Mastery/redefining the relationship with the loss

The intervention is drawn from Foy and Larson (2006) and was adapted to the Lebanese culture along with the inclusion of content from WHO training sessions in the Arabic language. These introduced concepts acceptable to the participants and allowed social interaction, disclosure of experiences within the cultural norms, and expression of feelings regarding the atrocities in a nonjudgmental environment.

Topics were presented using PowerPoint presentations during which participants' questions were answered and discussed. These were followed by in-depth discussions and sharing of related experiences. After each session, the therapists recorded field notes derived from observations about participants' questions, comments, interactions, and attendance. The field notes were later reviewed for similarities and grouped based on commonalities.

Demographic information was collected before the first session that included gender, marital status, age, number of children, educational level, employment, smoking (e.g., cigarettes, water pipe or *argileh*), alcohol use, and previous treatment, if any, sought for mental health problems.

After the last session, participants completed an evaluation form consisting of two open-ended questions and three rating scales from 1 to 4 (1 = *not satisfied*, 2 = *not applicable*, 3 = *satisfied*, and 4 = *extremely satisfied*). Participants rated achievement of their goals, the effectiveness of the sessions, and the topics that were addressed.

Findings

Sample Description

Although 14 individuals consented to take part in the intervention, a total of 10 participants (2 men and 8 women) attended. The mean age was 40.6 years. All participants were

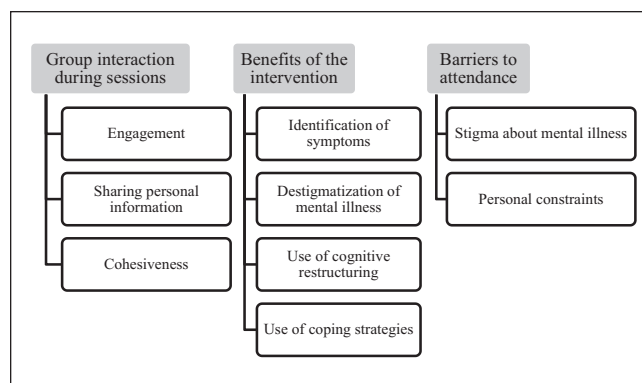


Figure 1. Commonalities derived from therapists' field notes taken during cognitive behavioral therapy sessions with civilians experiencing psychiatric symptoms from war-related trauma ($N = 10$).

married, and they had an average number of three children. In terms of education, 3 participants attained elementary education, 4 attained secondary education, and 3 reported higher than secondary education. Four of the 10 participants were unemployed. Only 2 participants had previously received treatment for mental health-related problems, both in the form psychopharmacotherapy.

After each session, the therapists recorded field notes derived from observations about participants' questions, comments, interactions, and attendance. These notes were reviewed and grouped into several thematic commonalities (Figure 1):

1. Group interaction during sessions: engagement, sharing of personal information, cohesiveness
2. Benefit from the intervention: identification of symptoms, destigmatization of mental illness, and use of cognitive restructuring and functional coping strategies
3. Barriers to attendance: stigma about mental illness and personal constraints

Group Interaction During Sessions

Since the initial contact and throughout the sessions, participants were engaged in the discussions, listened actively to the psychoeducational presentations, and showed interest in the sessions' content. During the group sessions, participants related the content of the sessions to their own and spontaneously shared personal experiences such as traumatic events experienced during war or displacement. They also described how it affected them and their families, expressing feelings of sadness, worry, and anxiety with flashbacks of the war events. One participant reported witnessing the bombing and death of the neighbors. She vividly remembered the view of their mutilated bodies and tearfully described the scene. Another participant shared pictures of her destroyed home that several enemy soldiers had occupied during wartime.

She described her sorrow when she saw her house and furniture severely damaged by the soldiers.

Similarly, when stress and coping strategies were discussed, group members shared ways in which they coped with daily stressors (i.e., going for a walk, praying, going to visit someone instead of staying home alone, and occupying self with daily chores). Additionally, participants discussed their complaints throughout the sessions such as insomnia, decreased concentration, irritability, and feelings of uncertainty or impending danger.

Benefits of the Intervention

Psychoeducation played an important and ongoing role during the sessions. Participants showed lack of knowledge related to psychiatric symptoms and disorders as well as the psychological effects of trauma. Following psychoeducation, several group members identified symptoms of trauma they have felt (i.e., flashbacks, avoidance of certain events, arousal); depression (i.e., depressed mood, sadness, crying spells, loss of pleasure, social withdrawal, feelings of worthlessness, pessimism); and anxiety (i.e., being anxious with obsessional thinking, tremors, fear, excessive worrying). The basic concept of psychosomatic symptoms was addressed. Group members were receptive and recognized the extent of their own somatization (i.e., headaches, epigastric pain, muscular pain, tremors).

Stigma of mental illness was an issue for the participants. The intervention's aims included educating participants on mental health and mental disorders, specifically trauma-related features with an emphasis on destigmatizing mental illness. Sessions were effective in debunking culturally acceptable myths surrounding mental illness such as the belief that mental illness is a personal flaw, a punishment from God, or a result of being possessed by *jin* or demons.

Participants shared similar patterns of pessimism toward the future, their financial situation, and the unstable political atmosphere in the area. They acknowledged the effects of this situation on their psychological well-being and learned to change negative thoughts into positive ones through cognitive restructuring. In later sessions, participants shared their attempts by mentioning, for example, "taking life day by day" to help decrease negative thoughts about the future and focus on positive aspects of daily life.

Participants described the sessions as a way to socialize and share their experiences. The sessions allowed for an increased self-awareness while acquiring valuable feedback in a therapeutic environment.

Barriers

The community in which the participants reside is one where misconceptions and stigma about mental illness are highly prevalent. It is a fairly rural community where engagement in social life is mutual among members, which in turn is a

double-bind issue: good for support, yet negative for stigma. As reported by one of the members, it was difficult joining psychological intervention sessions because of fear of being labeled by neighbors as having mental illness or being referred to as *majnoon* ("crazy" in the Lebanese spoken language).

There was also low attendance throughout some sessions. Personal constraints (i.e., work, health problems, and lack of time) and transportation to and from the sessions were identified as prominent barriers in this study (Figure 1). Public and personal means of transportation do not exist or are very limited in the area where the group sessions were held. This influenced the attendance rate and led to the absence of at least one participant per session.

Session Evaluations

During the last session, participants completed the evaluation form assessing goal achievement, perceived benefit of the sessions, and overall satisfaction with the intervention. Participants stated that they were satisfied with achievement of their goals. They also expressed satisfaction with the session format and the therapists' support. All participants reported that they would recommend this experience to others. The following summary goals were identified for the group: seeking education regarding mental health symptoms and treatment, developing social support, and enhancing coping strategies and resources for dealing with traumatic experiences.

Discussion

In areas where mass violence affects civilians and communities, it is crucial to establish effective treatments modalities for psychological disorders associated with trauma exposure. This study sought to provide CB group therapy in the south of Lebanon, an area continuously afflicted by war and instability, whose civilian population suffers high rates of psychiatric morbidity (Farhood & Dimassi, 2012; Farhood et al., 2006).

The intervention targeted war-traumatized individuals with a high need for coping with war stress and its treatment. Common factors observed during the sessions were war exposure and psychiatric symptoms of PTSD, depression, and anxiety. The nature of the war events reported by the participants is similar to those cited in other studies: namely, expulsion from their homes, damage to property, bombardment, and witnessing of murder or death (Priebe et al., 2010; Wolmer, Hamiel, Barchas, Slone, & Laor, 2011).

The sessions fostered a safe environment in which experiences and personal accounts of traumatic events were shared. This observation was reported by Akinsulure-Smith (2009) during a group intervention whereby participants valued socialization and social support that in turn fostered a sense of safety and comfort to share fears and concerns with others.

Participants in the current study also perceived the group as an opportunity to belong, to socialize, and to interact with members of their community. Beck and Coffey (2005) examined the benefit of group intervention in the treatment of PTSD compared with individual therapies. The authors highlighted the importance of the socialization that occurs during group sessions and the exchange of experiences that reveal similarities between participants. Universality and group cohesiveness were noticed in the current intervention and are well cited in the literature as therapeutic factors conducive to treatment efficacy in group therapy for trauma (Akinsulure-Smith, 2009; Beck & Coffey, 2005; Yalom, 2005).

Among the psychiatric symptoms reported, somatization was highly prevalent among participants. Studies have found that expressing symptoms through somatic complaints is considered socially acceptable in some cultures such as the Lebanese culture, where it is uncommon to express psychological distress for fear of stigmatization. This may in turn cause isolation and worsen psychiatric symptoms (Sayed, 2003). Kunsook and Bernstein (2007) have also reported somatization in the Korean culture as the syndrome of *Hwabung*, characterized by suppressed negative emotions and avoidance of confrontation, expressed as physical symptoms. The present intervention was successful in encouraging the participants to express psychological symptoms in the safe environment of the group, rather than concealing them and thus resulting in somatic symptoms. The relation between psychological distress and physical complaints became obvious through psychoeducation and CB therapy cognitive restructuring, which led the way to positive therapeutic outcomes.

Throughout the sessions, participants expressed a sense of constant impending danger, which contributed to a concern for safety and well-being. According to Laban, Gernaat, Komproe, van der Tweel, and De Jong (2005), these factors contribute to the development of PTSD. In the current study, trauma was addressed in terms of symptoms and its psychological impact. Additionally, emphasis was placed on providing positive coping strategies that would enhance resiliency in participants and decrease associated symptoms due to war atrocities. Group members shared coping strategies used to overcome daily stressors such as walking, praying, socializing, and distraction. Nordanger (2007) found similar strategies in an Ethiopian population coping with the devastating effects of war and subsequent life events. Avoiding negative emotions, specifically sorrow, through distraction rather than focusing on the traumatic event was a common coping mechanism.

Stigmatization of mental illness usually results in misconceptions and myths that could prevent individuals from seeking help for mental health concerns (Karam et al., 2006; Wang et al., 2007). Stigma of mental illness is pervasive within this group; participants stated that it was difficult to attend sessions based on fear of being labeled or stigmatized within their community and because of how cultural

expressions were often used to describe mental illness. These appeared to be based on misconceptions prevalent within the culture and mainly derived from commonly held belief systems. The family unit, for example, may reinforce an interpretation of mental illness based on the normalization of stigmas within the community (Sayed, 2003). This is also present in both the Korean and Soviet immigrant communities in the United States (Kunsook & Bernstein, 2007; Polyakova & Pacquiao, 2006). In these cultures, the expression of psychological concerns is not socially valued and may be considered as a sign of weakness. Lebanese families, similar to Korean ones, are encouraged to keep mental illness in their family a secret instead of seeking medical assistance, because it might be viewed as a dishonor to the family or a curse. In this group intervention and across other studies, psychoeducation was moderately successful in debunking myths about mental disorders and effective in enhancing social support, coping strategies, and mental health literacy (Foa, 2009; Gavrilovic, Schutzwahl, Fazel, & Priebe, 2005).

Limitations

Limitations included the low number of individuals who consented to participate as well as the variability in attendance of sessions. The lack of time, a lack of transportation, and the stigma of mental health were the main obstacles cited by participants. The absence of compensation for transportation or participation may have been a hindering factor. Individuals who consented to participate were probably motivated by the belief in the potential benefit of the intervention to them and clearly overcame the fear of being stigmatized for attending psychological sessions. Limitations also include the lack of follow-ups for participant progress. The time interval between the present intervention and the previous war trauma may also partly explain the low participation rate. Some individuals may have already used coping strategies to overcome the trauma such that the need for the intervention had diminished.

Conclusion and Recommendations

In light of the benefits reported by the participants as well as the difficulties in recruitment and attendance, this pilot study has served its aim by providing insight into conducting trauma-focused CB group therapy in the area of southern Lebanon. As a first attempt at conducting group therapy with war-traumatized Lebanese civilians, the present study has achieved positive outcomes through psychoeducation, destigmatization, and therapeutic group dynamics. Additionally, it has unveiled several barriers related to personal and cultural factors, valuable information for researchers who wish to plan future interventions in the area. Finding ways to overcome these obstacles is crucial to reach a higher number of civilians suffering from psychiatric symptoms and who are in need of mental health interventions.

To improve attendance and resolve the transportation problem, future interventions may be more efficient if conducted in the workplace. Public education to address mental health is needed for individuals to overcome the fear of being stigmatized for seeking treatment for mental health concerns. Understanding how trauma is perceived culturally may be an important factor in administering appropriate and effective treatments in diverse populations. Therefore, we recommend the use of focus groups before conducting studies in culturally sensitive areas such as the south of Lebanon, whose population has undergone continuous traumatic events for more than 20 years. To ensure sustainable and accessible mental health care, governmental and nongovernmental agencies should heed evidence-based policy recommendations and use available resources to develop local and national mental health structures that will aid the civilian population in times of conflict and peace.

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