Chapter

Lay Counselors' Mental Wellness in Suicide Prevention after Prolonged Mass Trauma: A Pre- and Post-Training Appraisal

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Abstract

Information on the mental wellness of lay counselors in Uganda is unavailable. Sixty representatives of three sub counties in Gulu District in Northern Uganda were equipped with counseling skills through 40 hours of training over 5 days. The trainees completed the 32-item Response Inventory for Stressful Life Events (RISLE) immediately before the commencement of the training and soon after the completion of the training. Pretest prevalence of suicide ideation was 9.3%, and posttest prevalence was 11.1%. Immediate post-training assessment showed better overall mental wellbeing as judged by overall RISLE scores, which were statistically significantly lower post-training than pre-training for gender (P = 0.05) and marital status (P = 0.001) on most RISLE scores. Qualitative assessment after 3 months of training showed that trainees were less suicidal, and they had improved psychosocial functioning. The current results point to the need to pay attention to the mental wellness of volunteer counselors and support them in their role in preventing suicide in areas of mass trauma. We recommend robust randomized community trials to determine the role of the mental wellbeing of volunteer lay counselors in the provision of psychological first aid to communities exposed to prolonged mass trauma.

Keywords: mass trauma, lay counselors, mental wellbeing, mental disorders, suicide ideation, suicidality, psychological first aid, northern Uganda

1. Introduction

Stress in the lives of humans under different names has attracted myriads of studies and publications since World War I (WW I). One of the most compelling books in the field is Herman's publication [1]. Protracted, catastrophic, and life-threatening events happen in daily life behind closed doors of families in the form of domestic violence, sexual abuse and defilement, political terror and wars, and natural disasters, and the diagnosis of terminal illness. Mental disorder in the form

of post-traumatic stress disorder (PTSD) is so complex that misdiagnoses are common. Another influential book by Varmik Volkan [2] theorize that society accepts "*widespread violence,*" which begins with what Volkan has described *"chosen trauma."* The defeat of one of the groups involved in intergroup conflict carries the painful memories of their humiliation for centuries as a result of historical details passed on from generation to generation in the hope that a future generation might be able to avenge them. Likewise, the victor in intergroup conflict keeps alive their chosen glory for as long as history can tell to ensure that their victory remains in memory. The stark implication of this is that traumatic stress remains in memory for the entire lives of affected people. According to Volkan, mass psychosis and suicide may follow organized ethnic or political violence. Several traumatic stress-related psychiatric disorders appear in the two main diagnostic systems, namely the Fifth Edition of the Diagnostic and Statistical Manual of Mental and Behavioral Disorders (DSM-V) of the American Psychiatric Association [3], and the eleventh edition of the International Classification of Diseases and Behavioral Disorders (ICD-11) of the World Health Organization [4].

Though not strictly a disorder, but rather, a consequence of other medical and psychiatric conditions, suicide has come to take a central position as one of the leading complications and comorbid health and social problems of stress disorders, occurring together with post-traumatic stress disorder (PTSD), depression, anxiety disorders, alcohol and substance use disorders, and general medical conditions. The risk of suicide is higher than in the general population as reported in anxiety disorders [5, 6], general physical conditions (Dome et al., 2019), and bipolar disorder [7]. In Uganda, a landlocked country in East Africa, a violent war took place between the Uganda government armed forces, the Uganda People's Defense Forces (UPDF), and a rebel army of the Lord's Resistance Army (LRA) in Northern Uganda from 1986 to 2006. Several publications have documented varying prevalence rates for depression, suicide, suicide ideation, and other consequences of the decade long civil war in Northern Uganda [8–10], Ovuga and Wasserman [11, 12].

As would be expected, one of the main goals of trauma therapy should aim to help trauma-affected persons to recover from trauma, minimize mental distress, improve community resilience and psychosocial functioning, and prevent suicide in the aftermath of mass trauma exposure. Unfortunately, little or no attempt aims to prevent suicide among trauma-exposed people. In situations of mass trauma, psychosocial support to trauma-exposed persons is limited to the provision of social amenities, the provision of protection and security guarantees, and other actions that aim to promote community cohesion and resilience. Suicide prevention work, which should be a key component of trauma therapy and psychosocial support, should include the creation of an awareness of potential self-destructive behavior occurring in communities affected by trauma. Following this step is the institution of measures to provide psychological services to trauma victims; and recognizing, assessing, and offering quality counseling services and specialist mental health care to people showing symptoms and signs of psychological distress or mental illness. An optimal outcome of such an intervention occurs when suicide prevention work takes place at community level close to where trauma victims live, and with the full participation of war-exposed communities. To do this, trained laypersons will deliver the suicide prevention therapy as an integral component of generic psychosocial support services [13]. A setback to this approach is the potential resistance of trauma-affected communities concerning the role of laypersons to deliver psychological first aid in

their own areas of abode. In the words of one community member, "*What can our colleagues do that we do not know? We live with them, they know our problems, and we have suffered with them. How can they help us?*"

The present chapter describes the outcome of training laypersons to deliver psychological support for distressed war-affected individuals in Gulu District in Northern Uganda. In doing so, we hypothesized that vulnerable members of traumatized people would show evidence of psychological distress even though they seem to "*function normally.*" If this is the case, we expected that laypersons would offer psychological services to their colleagues more effectively if they themselves receive psychological care before they assume responsibility for the psychological wellness of their distressed colleagues. We therefore hypothesized that training distressed war-affected individuals would constitute the means to improve their mental health.

2. Materials and methods

2.1 Selection of 60 lay counselor recruits

Leaders of the host communities of the participating volunteer lay counselors, based on the predefined criteria and in consultation with communities, selected the 60 trainees. Each person should have shown that they were kind, friendly, and approachable to other persons in distress, be willing to help distressed individuals, be trusted, be of good social standing, be male or female, be a youth or of older age, and be willing to work on voluntary basis. Preparations and selection process followed several levels of discussions as depicted in **Figure 1**.

The research team held several consultative meetings with Gulu District Officials, which delegated the District Community Development Officer (DCDO), as the contact person to oversee the suicide prevention initiative. The DCDO accordingly appointed the various Assistant Community Development Officers (ACDOs) based in the Sub Counties of District. The ACDOs in term granted authority to the Parish Community Development Officers (PCDOs) of the participating parishes. Each PCDO selected lay community volunteers for the training. The goals of the consultative meetings, preparation, and processes were to gather information from the various stakeholders about suicidal behavior, introduce a self-help community response to the wave of self-destructive behavior at the time, explain the mental health philosophy behind the response, and align it with the prevailing traditional, cultural, and religious belief systems concerning suicidal behavior.

There were 20 participants at each of three Sub-County Headquarters. The trainers were a senior psychiatrist, a clinical psychologist who was a doctoral research student, two social workers, and a senior physician assistant in mental health. Training consisted of 8 hours of a review of the learning objectives of the previous day, a short introductory talk by one of the trainers on the areas to cover during the day, life problems that commonly cause psychological or social distress, plenary discussions, and examples of recent suicide or suicide attempt, or other life problems. The short introductory lecture on the very first day of training provided an overview of the entire 5-day training. The assessment of mental wellbeing followed the overview of the training after which the training progressed smoothly. In the course of the training, each trainee provided personal accounts of their own difficulties whenever they wished to. In this way, the trainers supported the

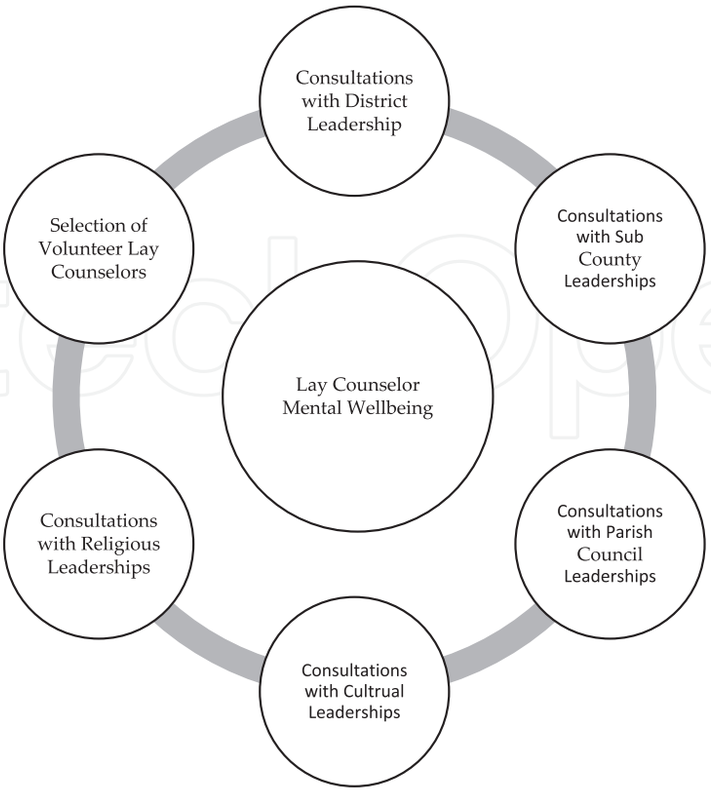

Figure 1.
Preparation and process of selection of volunteer lay counselors.

individual to tell their own lived story, and the rest of the trainees to listen without interruption or show of judgmental attitude. The training reference material was a standard mental health teaching methodology adopted in Uganda's health training institutions [13].

2.2 Self-assessment

Every selected layperson participated in two waves of self-assessment for the risk of suicide behavior; the first wave of self-assessment took place immediately prior to the start of training, and the second wave, at the close of the training. Participants used the revised 32-item Response Inventory for Stressful Life Events (RISLE) [12] to determine their suicidal behavior risk. The participating laypersons were members of the same communities that lived with the experience of distress in the forms of suicide, suicide attempts, suicide ideation, alcohol use disorders, and domestic violence. The underlying principles in suicide risk self-assessments were as follows:

a. Since the volunteer lay counselors experienced the decade long brutal war in Northern Uganda, as the rest of their community members, it would be expected that they too would show evidence of psychological distress;

b. It would be ethically prudent to offer psychological support to participants who screened positive for suicidal behavior; and

c. Because of training, laypersons who screened positive for psychological distress would benefit from the experience of training.

2.3 Instruments and screening for mental wellbeing

2.3.1 Conceptual framework of the Response Inventory for Stressful Events (RISLE)

Figure 2 presents the conceptual framework of three factors that interact in dynamic ways to engender suicidal behavior. An interaction of two of these factors, depicted as *individual predisposition*, *stressful life events*, and *quality of social capital*, may lead to impulsive self-destructive act or deliberate self-harm, failed suicide act, completed suicide act, recurrent suicide ideation, or repeated suicide urge in response to the experience of difficulties in life. Individual predisposition may take the form of genetic predisposition, the existence of a major psychiatric disorder such as major depressive disorder, affective disorder, or schizophrenia; the diagnosis of a debilitating somatic illness or terminal illness such as malignancy, or an endocrine disorder such as diabetes mellitus. Examples of stressful life events are multiple, and these include unexpected business collapse, loss of employment, failed marriage or sudden end of a relationship, teenage pregnancy, domestic violence, and dropping out of school due to lack of school fees. Examples of quality of social capital include lack of social support to elderly parents who, as a result, may choose to end their lives. Constant harassment of a child or teen by stepmother, neglect of a child by a father, and child abuse or defilement are often potent risk factors for suicidal behavior.

The actual occurrence of a lethal suicidal act happens when all three factors (individual predisposition, a stressful life event, and lack of social capital) act in combination and create the environment for the affected person to view life as intolerable, hopeless, worthless, and meaningless.

2.3.2 The RISLE and self-assessment

Table 1 presents the content of the Response Inventory for Stressful Life Events (RISLE). The instrument consists of five subscales that comprise of items, which describe situations relating to one or other of the three pillars of suicidal behavior.

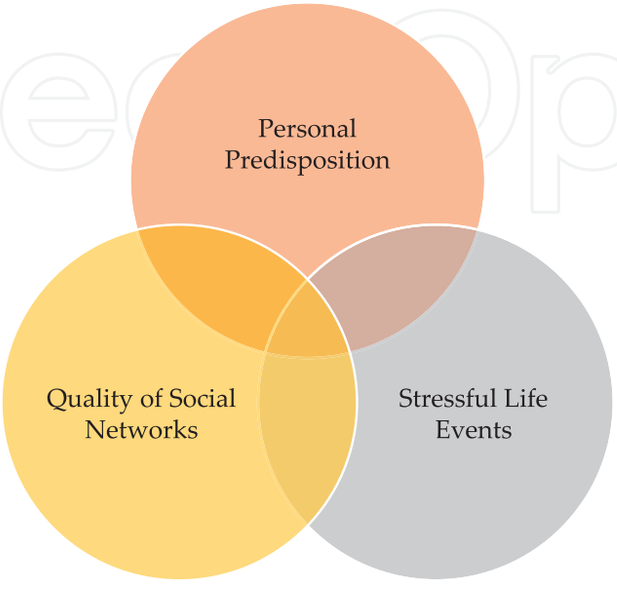

Figure 2.
Three pillars of suicide behavior.

	Variable	Sex (females = 0, males = 1) (95% CI)	Marital status (other = 0, married = 1) (95% CI)	Age (34 and less = 0, 35 and above = 1) (95% CI)
1.	Life is intolerable	−0.32 (−0.49 to − 0.15) P; 0.000***	−0.13 (CI −0.28 to 0.01) P; 0.08	0.04 (CI −0.10 to 0.18) P; 0.54
2.	Life is hell on earth	−0.08 (−0.21 to 0.05) P; 0.25	−0.10 (CI −0.22 to 0.01) P; 0.08	−0.02 (CI −0.12 to 0.09) P; 0.74
3.	The world has nothing to offer	−0.02 (−0.15 to 0.11) P; 0.77	−0.05 (CI -0.16 to 0.07) P; 0.43	−0.08 (CI −0.19 to 0.03) P; 0.15
4.	Wish to be out of this world	−0.11 (−0.22 to − 0.01) P; 0.04*	−0.05 (CI −0.14 to 0.04) P; 0.28	0.001 (CI −0.09 to 0.09) P; 0.97
5.	Extent of pain	−0.064 (−0.24 to 0.11) P; 0.46	−0.05 (CI −0.20 to 0.10) P; 0.50	−0.07 (CI −0.21 to 0.07) P; 0.29
6.	Reaction to latest hardship	0.06 (−0.36 to 0.02) P; 0.68	−0.24 (CI −0.50 to 0.02) P; 0.08	0.06 (CI −0.19 to 0.30) P; 0.64
7.	Nervousness	−0.13 (−0.45 to 0.19) P; 0.42	0.002 (CI -0.29 to 0.28) P; 0.99	0.04 (CI −0.22 to 0.30) P; 0.77
8.	Confusion	−0.19 (−0.49 to 0.11) P; 0.22	−0.31 (CI −0.58 to − 0.05) P; 0.02*	−0.71 (CI −0.20 to 0.29) P; 0.71
9.	Difficult times	−0.07 (−0.25 to 0.11) P; 0.44	−0.17 (−0.32 to − 0.01) P; 0.04*	0.03 (CI −0.11 to 0.18) P; 0.64
10.	Kill myself immediately	−0.09 (−0.29 to 0.04) P; 0.16	−0.03 (CI −0.15 to 0.08) P; 0.57	0.04 (CI −0.07 to 0.15) P; 0.47
11.	Kill myself after business collapses	0.04 (−0.07 to 0.15) P; 0.48	0.03 (CI −0.06 to 0.13) P; 0.50	0.08 (CI −0.01 to 0.17) P; 0.09
12.	Worry	−0.01 (−0.29 to 0.29) P; 0.94	−0.003 (CI −0.24 to 0.24) P; 0.98	−0.02 (CI −0.24 to 0.21) P; 0.89
13.	Kill myself before they do so	−0.17 (−0.34 to − 0.001) P; 0.05*	−0.21 (CI −0.36 to − 0.07) P; 0.005**	−0.02 (CI −0.16 to 0.11) P; 0.73
14.	Give myself one more chance	−0.17 (−0.35 to 0.004) P; 0.06	−0.13 (CI −0.29 to 0.02) P; 0.08	0.02 (CI −0.12 to 0.16) P; 0.77
15.	No way out	−0.13 (−0.27 to 0.02) P; 0.09	−0.13 (CI −0.26 to − 0.004) P; 0.04*	0.02 (CI −0.10 to 0.13) P; 0.79

	Variable	Sex (females = 0, males = 1) (95% CI)	Marital status (other = 0, married = 1) (95% CI)	Age (34 and less = 0, 35 and above = 1) (95% CI)
16.	Relieve relatives of problems	−0.17 (−0.32 to − 0.01) P; 0.03*	−0.17 (CI −0.30 to − 0.04) P; 0.01*	0.12 (CI −0.01 to 0.24) P; 0.06
17.	Remind relatives of responsibilities	−0.10 (−0.33 to 0.13) P; 0.38	−0.18 (CI −0.38 to 0.02) P; 0.08	0.22 (CI 0.03 to 0.41) P; 0.02*
18.	Punish my relatives	−0.14 (−0.25 to − 0.040 P; 0.01*	0.03 (CI −0.07 to 0.12) P; 0.58	−0.01 (CI −0.09 to 0.08) P; 0.87
19.	Teach my relatives a lesson	−0.09 (−0.32 to 0.14) P; 0.45	−0.13 (CI −0.33 to 0.07) P; 0.21	0.05 (CI −0.14 to 0.24) P; 0.60
20.	Die to get away from problems	−0.01 (−0.14 to 0.13) P; 0.92	−0.06 (C–I 0.17 to 0.06) P; 0.36	−0.01(CI −0.12 to 0.10) P; 0.81
21.	Death solution to problems	−0.06 (−0.14 to 0.02) P; 0.12	−0.02 (CI −0.09 to 0.05) P; 0.53	−0.03 (CI −0.10 to 0.03) P; 0.31
22.	Go to another town	−0.27 (−0.56 to 0.01) P; 0.06	−0.09 (CI −0.34 to 0.16) P; 0.49	−0.19 (CI −0.42 to 0.04) P; 0.11
23.	Wish died with relatives	−0.08 (−0.27 to 0.12) P; 0.44	−0.13 (CI −0.30 to 0.04) P; 0.13	−0.06 (CI −0.22 to 0.10) 0.46
24.	Wish kill myself	−0.03 (−0.14 to 0.08) P; 0.59	−0.07 (CI −0.17 to 0.02) P; 0.13	−0.05 (CI −0.14 to 0.04) P; 0.28
25.	Kill myself to end suffering	−0.14 (−0.29 to 0.004) P; 0.06	−0.12 (CI −0.25 to 0.004) P; 0.06	−0.05 (CI −0.17 to 0.07) P; 0.39
26.	Kill myself before full features develop	−0.16 (−0.29 to − 0.04) P; 0.01*	−0.08 (CI −0.19 to 0.03) P; 0.15	0.04 (CI −0.07 to 0.14) P; 0.49
27.	Lost control	−0.07 (−0.25 to 0.11) P; 0.44	−0.17 (CI −0.32 to − 0.01) P; 0.04*	0.03 (CI −0.11 to 0.18) P; 0.64
28.	Wish to be dead than alive	−0.16 (−0.31 to − 0.01) P; 0.04*	−0.05 (CI −0.18 to 0.08) P; 0.41	0.01(CI −0.11 to 0.13) P; 0.91
29.	End life rather than live with problems	−0.09 (−0.22 to 0.04) P; 0.17	−0.09 (CI −0.21 to 0.02) P; 0.10	−0.09 (CI−0.19 to 0.02) P; 0.11
30.	No appreciation	0.05 (−0.22 to 0.32) P; 0.70	−0.07 (CI −0.30 to 0.17) P; 0.57	0.02 (CI−0.20 to 0.24) P; 0.88

	Variable	Sex (females = 0, males = 1) (95% CI)	Marital status (other = 0, married = 1) (95% CI)	Age (34 and less = 0, 35 and above = 1) (95% CI)
31.	Wonder why born	−0.18 (−0.42 to 0.08) P; 0.15	−0.16 (CI −0.36 to 0.05) P; 0.14	0.01(CI−0.19 to 0.20) P; 0.94
32.	No practical assistance	−0.23 (−0.52 to 0.06) P; 0.11	−0.01 (CI −0.26 to 0.24) P; 0.92	−0.12 (CI −0.35 to 0.12) P; 0.32
33.	All variables	−2.11 (−4.21 to −0.02) P; 0.05*	−3.36 (−5.22 to −1.49) P; 0.001**	−0.08 (−1.78 to 1.63) P; 0.93

**Significant at P < 0.05.*
***Significant at P < 0.001.*
****Significant at P < 0.000.*

Table 1.
RISLE regression analysis for the mean scores with sex, marital status, and age of participants as demographic characteristics post-training.

The subscales are *Reaction to stressful events, Attitude to the social world, Attitude to life, Passive death wishes,* and *Active death wishes.* Suicidal persons have poor ability to adapt to and manage stressful events. The characteristic response to encounters with stressors, however minor, is bewilderment, confusion, and failure to be at ease. The overall pattern of behavior in the face of difficulties is maladaptive. Suicidal behavior in the Ugandan setting occurs in an environment of rich social networks. However, suicidal persons view their social networks as not being supportive; their attitude to their social networks is thus negative. In the face of life's difficulties, suicidal individuals view their life situation as intolerable, unbearable; they view themselves as having lost control over their personal and social lives. Passive death wishes refer to a constellation of thoughts, feelings, and urges reminiscent of suicide. Active death wishes, on the other hand, refer to thoughts, plans, and other activities that precede and culminate in a completed suicide. The score on the RISLE is the total of the scores on the five subscales. A high score indicates a high suicide risk. Details of how the score on the RISLE validation is described elsewhere.

In addition to the actual measures of responses to stressors, the RISLE has a section that captures sociodemographic characteristics of every respondent. The instrument is self-administered and asks the respondent to provide his or her response to the experience of each stressful event in the 2 weeks prior to the self-assessment. Respondents choose from one out of four possible responses to every stressful event. The four alternative responses grade the respondent's potential response from a positive and adaptive reaction to a negative maladaptive response depending on his or her life experiences. The content of the RISLE describes the presence of any chronic somatic illness such as HIV/AIDS, the respondent's adequacy of social support, type and level of stress tolerability such as in response to marital difficulty or business collapse, coping ability, and adaptive behavior in the face of difficulty such as impending natural death or execution for murder, etc. Trainee lay counselors completed the 32-item translated *Luo* version of the RISLE questionnaire [11, 12] on the first day of training and immediately after the end of training on the fifth day.

2.4 Statistical analyses

Multivariable logistic regression using STATA version 11.2 determined if there was a significant difference in mean RISLE scores between males and females, on the basis of marital status, and between respondents aged 35 years and older and those aged 34 years and younger (See **Table 1** above). The potential outcome of training on the mental wellness of trainee lay counselors. Three months post-training, three lay counselors who scored positive for suicidality and depression participated in in-depth interviews during support supervision by two of the trainers. The findings from in-depth interviews appear in the section of summaries in the following section. Uganda National Council for Science and Technology (UNCST, SS3678) and St. Mary's Hospital Lacor Ethics Review Committee (054/09/14) provided approval for the suicide prevention in the community.

3. Results

3.1 General characteristics

Seventy-eight percent of the respondents were male, and 100% were Christian. The mean ages of males and females were not statistically significantly different. Sixty trainees participated in the training, but only 48 had complete test scores for pretest and posttest scores. Of the 12 trainees that missed either pretest or posttest screens, 6 were absent at the time of the posttest assessment while 10 missed the pretest assessment. Of the 54 trainees who took the pretest assessment, 5 (9.3%) screened positive for medium to high suicide risk. At posttest assessment, 6 trainees out of 54 (11.1%) screened positive for suicidality. Part of the explanation for the higher proportion of trainees screening positive for medium to high suicide risk lies in the respective trainees having joined the training on the second or third day of training. Because of this, the trainees missed much of the information and discussion about psychosocial distress that results from exposure to traumatic stress.

3.2 Independent t-test (RISLE)

Immediate post-training assessment indicated statistically significant overall reductions in RISLE mean scores based on gender (−2.11, 95% CI -4.21 to −0.02, P = 0.05) and marital status (−3.36, 95% CI -5.22 to −1.49, P = 0.001). The reductions in test items based on gender levels occurred for *"life is intolerable"* P = 0.000), *"wish to be out of this world"* (P = 0.04), *and "kill myself before the authorities execute me for alleged murder"* (P = 0.05). Other statistically significant reductions occurred for *"relieve my relatives of my problems"* (P = 0.03), *"punish my relatives"* (P = 0.01), *"kill myself before the full features of HIV/AIDS show up"* (P = 0.01), and *"wish to be dead than alive"* (P = 0.04). Based on marital status, significant reductions in RISLE mean scores occurred for *"during difficult times"* (P = 0.04), *"kill myself before they do so for alleged murder"* (P = 0.005), "if there is no way out" (P = 0.01), *"relieve relatives of my problems"* (P = 0.01), and *"lost control"* (P = 0.04). However RISLE mean score increased significantly for respondents aged 35 years and older over those aged less than 35 years for the test item regarding social support from significant others *"remind relatives of their responsibilities"* (P = 0.02).

3.3 Findings on support supervision

Three months after training, a doctoral student and member of the trainers conducted support supervision. During the supervisions, three of the lay counselors who had high scores on the RISLE indicative of severe suicide risk reported significantly improved mental health with better social functioning as summarized as follows.

3.4 Female lay counselor, 27 years old

Because of marital problems gone out of control, the 27 years old woman separated from the husband. The husband was a heavy user of alcohol, and in his drunken state, he fought the woman every night. For safety reasons the woman and her three children used the food store as their bedroom. Consequently, there was no sexual relationship between her and the man. After her separation, the husband married two more wives. Following the training, the woman helped her family by talking to the husband resulting into reconciliation. She herself accepted the reality of life with two co-wives. The woman reported that the training she received benefited her because she had become important in her community, solving community and family problems. Although she had been suicidal prior to the training, the woman no longer felt the urge to die by suicide. The most important achievement she made was that she established liaison with the police department in her parish so that individuals that attempted suicide did not have to face prosecution. Instead, suicide attempters received referral to the Regional Referral Hospital where mental health professionals practiced.

3.5 Female lay counselor, 38 years old

This 38 years old female counselor had a husband who drank alcohol heavily. Because she was lame in one leg, her husband's relatives did not wish her well and urged him to marry another wife who was whole and healthy. The woman lost desire for sex and wanted to go far away from home to a distant place to live all by herself. After the training, the woman felt happy, and her husband stopped using alcohol because she talked to him post-training. The woman felt confident, could handle personal problems, did not feel suicidal and she felt stable in life. Moreover, the woman realized that using her personal life story during counseling sessions with clients helped them to recover. The woman's work as a lay counselor has increased her network of friends.

3.6 Sixty years old male lay counselor

This 60 years old male lay counselor described himself as mentally sick before training. The man described features of moderate major depressive disorder characterized by peculiar sadness, inability to sleep, worrying and thoughts about his problems, thoughts about dying, and the experience of muscle cramps and pains. He described himself as rough that he used to shout at his wife and children all the time before training. On one occasion, the man confided to his wife that he lived in two spirit worlds, one that invited him to die by hanging, and the other, to stay alive. The training completely transformed the life of this senior citizen, and he became a role model for all males, young or older, to follow his way of life. Because of this, the

60 years old lay counselor reported that he no long had any work to do, as there were no cases of domestic violence and alcohol abuse in his village.

4. Discussion

In the course of two decades of brutal civil war in Northern Uganda between a rebel army, The Lord's Resistance Army (LRA), and government forces, the Uganda Peoples' Defense Forces (UPDF), 98% of the population experienced firsthand the atrocities that occurred in the north of the country. The war left many with bitter hearts and memories [8, 14]. In a review of research done in Northern Uganda, Dokkedhal et al. [15] reported a review of the literature on the widespread harmful mental health outcomes of the Northern Uganda war on the population. Even children were not exempt, and Ovuga and Larroque [16] and Ovuga et al. [17] reported the mental health, suicidal, and physical health effects of the work on children. An epidemic of suicidal behavior followed the people in the region attributed to the spirits of the dead who died in the crossfire. The locals also attributed some of the suicides to excessive consumption of alcohol, domestic violence, and widespread poverty as well as genetic or familial factors, as they observed that not everyone but members of certain families and clans who were prone to commit suicide did so. Religious leaders, on the other hand, explained the suicides on demonic possessions. Against this background, this chapter describes the processes and outcomes of training volunteer lay counselors in response to the emergence of the suicide epidemic. An earlier experience in the neighboring district of Adjumani showed that volunteer lay counselors and put down the rate of suicide in that district by integrating mental health services in the general district health service [18].

A pre-training self-assessment of suicide risk among the volunteer lay counselor recruits indicated that 9.3% of the participants scored highly for suicidality, while post-training assessment indicated that 11.1% of the trainees were suicidal. These rates were comparable to the study of Ovuga et al. [10]. The higher post-training score for suicidality arose out of the fact that some of the individuals who did self-assessment post-training were not present during the pretest and on 3 days of the 5 days training period. In the course of training and thereafter, three members of the training team continued to provide psychological support to the lay counselors to improve the counselors' personal mental wellbeing and to provide advice and guidance in how to proceed with the work of helping people in distress. The training took the form of *"experiential training*," meaning that the methods of instruction used lived experiences to create relevance, meaning, and understanding of mental health and suicide prevention concepts.

Results of the suicide prevention program were a participatory community response to the wave of suicides in Gulu District. The results showed that 9.3–11.1% of recruits whom their community leaders selected for training were initially suicidal, even though the recruits appeared "*normal.*" Based on the content and structure of the Response Inventory for Stressful Life Events (RISLE), the training centered on equipping the trainees to pay attention to the origins of suicidal feelings in daily living. Suicide in Uganda is a criminal act, and a failed suicide bid is liable to criminal prosecution [16]. Because of this, the trainees received in-depth training on the ethics of counseling, lasting 6 hours of introductory talk, exercises, group discussions, and a plenary session. Post-training self-assessment showed better overall mental wellbeing among the trainees. According to Haney et al. [19], it is risky to predict the outcome

of suicide research. Suicide ideation is a personal matter. Some distressed and suicidal individuals therefore tend to be secretive. The fear associated with talking to suicidal individuals within a research atmosphere is the possibility of introducing the courage and determination for them to implement their suicidal urge. Because of this, those who screened positive for moderately severe suicidal risk received in-training psychological support in addition to ongoing professional support supervision after the training.

The current results suggest that training in small groups can result in improved mental wellbeing among individuals who have experienced prolonged mass trauma. This conclusion arises from the results of logistic regression that indicated significant reductions in mean RISLE item scores for several component items, namely stress toleration, coping abilities in difficult situations, improved attitude to social support, and reduction in maladaptive behavior as an escape strategy in difficult circumstances. The results further suggest that males benefitted more from the training than did females. Similarly, the married also benefitted from the training more than those who were not. It is possible that men learned coping skills from the training faster than females. However, it is also possible that females took long to work through the cumulative effects of domestic violence, which mainly affected them. For the married, it appears that those who were married were able to relate their own roles in their respective marital difficulties practically and were therefore able to plan to use their knowledge and skills to address marital problems as the training progressed.

The drawbacks in the current study stem from the fact that the study was an emergency response to a community outcry and need. To address this limitation, a larger and randomized study aimed to improve overall mental wellbeing in the community would be beneficial. Not every one of the lay counselor recruits participated in the training or self-assessments. However, the results suggest that training in mental health can lead to improved mental wellbeing, as reported by Haney et al. [19]. Nine African countries including Uganda participated in a World Health Organisation (WHO) study, which investigated, through training, the effect of raising awareness on mental health issues among secondary school students, their parents and teachers in representative schools in each of the countries. In that study, awareness was raised using printed materials specifically developed for the purpose, and distributed to the students, their parents and teachers. In the case of Uganda the study took place in randomly selected schools in the districts of Kampala and Wakiso. Results from the nine countries cos countries showed that raising awareness about mental health and well-being led to improved attitude toward individuals with mental illness after two weeks of training. Secondly, students who received awareness training indicated that they would seek help for their colleagues that might show signs of mental illness. The same results applied to teachers and respective parents of the students that participated in the study [19]. These results show support for the recommendation for using strategies to improve the mental health of individuals who volunteer to deliver first aid mental health services for people in crisis. Nevertheless, the small sample size probably limited the levels of significance that a larger and randomized sample size would have provided. The fact that ongoing support supervision revealed improved confidence, psychosocial wellbeing, and functioning suggests that the training had a positive impact on the lives of the lay counselors. The present results therefore demonstrate that trained lay counselors, with support supervision, can win the confidence of the community, promote mental health in the community, and help to prevent or at least control suicide after very traumatic stress. It is important that using volunteer

lay counselors to deliver counseling services should be of very sound mind, hence the need for their prior training and support supervision.

5. Conclusion

Following 20 years of very traumatic stress resulting from exposure to civil war in Northern Uganda, there arose an epidemic of mass suicide in all communities. In response to community outcry ranging from official civic and political leaders through religious leaders to members of rural communities, Gulu University Department of Mental Health established a suicide prevention program. By training and providing support supervision, 60 volunteer lay counselors achieved improved mental wellbeing and psychosocial functioning. We recommend a replication of this emergency response, as it promises to enable rural communities with limited access to professional mental health service cope with the detrimental effects of very severe traumatic stress.

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Conflict of interest

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Acronyms and abbreviations

DSM-V	Diagnostic and Statistical Manual of Mental and Behavioral Disorders, 5th edition
ICD-11	Eleventh edition of the International Classification of Diseases
LRA	Lord's Resistance Army
MIN	Mini International Neuropsychiatric Interview
RISLE	Response Inventory for Stressful Life Events
UPDF	Uganda People's Defence Forces
WHO	World Health Organization

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