Mental health in war-affected populations

Scholte, W.F.

Citation for published version (APA):
Scholte, W. F. (2013). Mental health in war-affected populations

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: http://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.
Chapter 5

Community-based sociotherapy in Byumba, Rwanda

Richters A
Dekker C
Scholte WF

Adapted from article published in: Intervention 2008; 6(2): 100-116.
5. Community based sociotherapy in Byumba, Rwanda

Summary
A community-based sociotherapy program was implemented in the North of Rwanda in 2005; it is still running. Over the first 27 months of the program's course, 3700 beneficiaries participated in the intervention groups. This chapter describes the context of the setting and the backgrounds of sociotherapy. It explains its principles, and argues why the introduction of this approach was appropriate in postgenocide Rwanda. It then focuses on the development and implementation of the program, and the reception by its various stakeholders.

Introduction
The Byumba Diocese of the Episcopal Church of Rwanda (EER; Eglise Episcopale au Rwanda) started a sociotherapy program in the Byumba province* of Rwanda in September 2005. The local population is severely affected by a history of war which finally resulted in a genocide. The goal of the program was to help establish social re-bonding and reduce mental distress. After a training period of 3 months and an additional month of field preparation, sociotherapy groups started to function in January 2006 in a selection of areas spread over the province. Soon after, stakeholders started to express their appreciation of the program and its results. During a conference in Rwanda's capital city Kigali in January 2007, the Byumba sociotherapy program was introduced to practitioners and policy makers working in the areas of mental health, trauma counselling, psychosocial care and reconciliation in Rwanda and its neighbouring countries. The conference and subsequent exchanges with practitioners and policy makers resulted in an expansion of the sociotherapy activities to other areas of Byumba province, the introduction of a program in South Kivu, Congo, and the preparation of programs in other regions of Rwanda.

Byumba in context
The former Byumba province is located in the north of Rwanda; it borders Uganda. The invasion by the Rwanda Patriotic Front (RPF) from Uganda into Rwanda in 1990 marked the start of a civil war in the north of the country. Many

* In January 2006, the Rwandan government established new provinces, five in total. Byumba Province, one of the previous twelve provinces, was divided up. One part now belongs to the new North Province and the other part to the new East Province. Byumba Diocese still covers the same geographical area as before. In this chapter, that area is still referred to as Byumba province. Also, the name the Episcopal Church of Rwanda was recently changed to Anglican Church of Rwanda. In this chapter, however, the old name EER will be used.
members of the RPF, predominantly of Tutsi origin, were second-generation refugees who had fled to Uganda and settled there from 1959 onwards, escaping the ethnic purges in Rwanda. The RPF entered Rwanda as an army of liberation, but was perceived by the majority of the population as an army of occupation. Over the following years, the invasion led to massive displacements of people to refugee camps further south in Rwanda. Low-intensity fighting alternated with massacres, including one in Byumba. During and after the 1994 genocide, people fled to refugee camps in neighbouring countries where they stayed for several years.¹

The war (1990-1994) and the genocide (1994) affected men, women and children of all ages. The population experienced ceaseless atrocities, such as killings, sexual violence, torture, destruction of property, and social rejection. Over the second half of the 1990s and the first half of the 2000s, a substantial part of the population consisted of widows, widowers, orphans, physically disabled persons, prisoners and ex-prisoners. As a representative of the Byumba Diocese put it: “There was a general feeling of insecurity, powerlessness and despair among the population. Many displayed a loss of self-care and -interest, and a lack of future perspective. Some showed frequent aggressive outbursts. Others were aimlessly wandering around without courage or a plan to survive.”

The return of displaced persons and refugees after the genocide generated additional problems, that were related to a complicated reintegration process. Within the population, categories of people could be distinguished that were each vulnerable for specific reasons:

- Women. Almost 60% of the Byumba population is female. Men had been the main targets of the killings or were still in prison, leaving many women behind. Life had been, and still was, harsh for women in particular. They had been exposed to violence, rape, and loss of family members and properties. For many, education had stopped abruptly during the war and never started again. Many had lived in refugee camps. All women and children (often accompanied by one or more adopted orphans) returning from the camps had been confronted with a disrupted society. Some had had to take on previous tasks of husbands and sons who stayed in prison.

- Released prisoners. Upon their return, released prisoners found they had lost their jobs, properties and roles in society. Many experienced domestic problems, e.g., their wife might have brought another man into the home or might have given birth to another man’s children. Female prisoners might have found their husband married to another woman. The sudden release of groups of prisoners in 2003 had also caused increased fear in society, which added to the ex-prisoners’ difficulties to cope.
- Orphans. Whether blood-related to their host families or not, orphans were not always treated equally to the father’s and/or mother’s own children, and were often marginalized from their communities. Another group of orphaned children had started heading households themselves, thereby taking care of younger brothers or sisters without the necessary means to do so properly.
- Other particularly vulnerable groups were single mothers, people living with HIV/AIDS, youngsters who were jobless, victims of domestic violence, and wives/widows in/of polygamous marriages.

Extreme poverty is one issue that cut across all categories and affected the majority of people. Byumba province’s poverty percentage is above the country average. The average income per family per month is around US $10. Poverty is one of the reasons for the many conflicts over property. Poverty is also closely related to a lack of education. A third of the children below 15 years of age lack education, and only a very small minority receive secondary or postsecondary education. Almost half of the adult population is illiterate. The proportion of people infected with HIV/AIDS is also above the country average.

**Sociotherapy**

The idea to offer sociotherapy to populations in postconflict countries was born in Dutch refugee clinics, where participants in sociotherapy groups expressed the wish that “their people at home had known this method before the conflicts erupted into violence.”

Sociotherapy has been practiced in Europe in group settings called therapeutic communities. The foundations of the sociotherapeutic approach were laid by British psychiatrists during the Second World War, when society had to cope with many psychiatric casualties of war. Rapoport characterized the approach as it had developed since as ‘community acting as a doctor’.

Since the 1970s, sociotherapy is an element of the mental health care provision in various clinical settings in the Netherlands. Bierenbroodspot, a main instigator of this development, incorporated the basic principles underlying sociotherapy (democracy, nondirectivity, equality, a focus on reality, and an orientation to the future) into the following practical-technical rules: 1) two-way communication at all levels; this warrants that all participants are informed about what goes on in a group, and can use that information in decision-making; 2) decision-making at all levels; this promotes, among other things, sympathy with a group as a whole and with its individual members; 3) shared leadership; this actually means democracy, the sharing of power and responsibility; 4) consensus in decision-making; no decision is forced, and discussion continues until consensus
Community-based sociotherapy in Byumba, Rwanda

is reached; 5) social learning by actual social interaction; this learning will also benefit group participants in their social interaction in the wider society. Sociotherapy differs from psychotherapy by its therapeutical use of the milieu—the totality of the setting in which the listed principles and methods are applied—as a model that confronts a person with his ‘outside world’. This is contrary to confronting an individual with his ‘inside world’ during psychotherapy. Over the last two decades, sociotherapy as a therapeutic group-approach has been adapted for the treatment of victims of political violence and war. This particularly happened in two clinics providing mental health services for traumatized refugees who now reside in the Netherlands (Stichting Centrum ’45 and Equator Foundation). As the approach was to be adapted for use with refugees instead of Dutch patients, the main issue requiring revision was its sensitivity to cultural, social, and political aspects of (mental) health problems. It also had to be attuned to the particular fragility of feelings of safety among survivors of violence. For example, because such feelings may easily be triggered or increased among group participants, group facilitators must take on a regulating role in the starting phase of group sessions, and only slowly delegate responsibility (e.g., for decision making) to the participants. Facilitators also need to be sensitive to the social, political and cultural aspects of issues of proximity and distance, and to dissolve tensions in case of disrespectful communication and enemy projections.

Facilitating a sociotherapy group

Facilitating a sociotherapy group requires an open-minded and observing listening attitude. The main issue for a starting group is the ‘inter-esse’; how participants handle the interpersonal space and the tension commonly caused by unfamiliar togetherness. Group facilitators apply didactical forms to gradually question daily social norms that limit participants’ space. How do participants deal with different values, norms, expectations, as well as positive and negative experiences? A facilitator’s sensitivity and skills in handling fragile social relations is a key determinant for the way the first phase of a group process develops. This, combined with the potential social power of a given group, determines the dynamics, development, and effectiveness of a sociotherapy group. According to de Vries, sensitivity is founded on in-depth knowledge of the political, socio-cultural and personal experiential dimensions of the context in which group members live, and from which their problems originate. Key questions for facilitators of sociotherapy groups of war-affected participants are: is the observed behavior perceived as normal in the particular postconflict
situation? How do people affected by extreme forms of political violence share common space?

Vignette

The following quote from a facilitator, explaining what dignity means in the context of sociotherapy, illustrates characteristics of a facilitator: knowledge of the social context, an open mind, the ability to question social norms, and not impose one’s own views.

“You all know that in the past a girl who gives birth to a child before marriage was rejected; dumped in hostile areas to die there. Even nowadays people call a child born in that way ‘ikinyendaro’ (a bastard). Of course this is degrading for both the mother and the child. For that single mother, her dignity was lost. A few months ago, there were local youth leader elections. I remember there was a lady, who was single mother, who was campaigning. She felt enough self-confidence and dignity to do so. Normally voters ask the candidate questions. In her attempt to counter those who might oppose against her single motherhood, she said, ‘I am so and so, I have done six years of secondary school but I have a child at home.’ As soon as she had said that, all people who had gathered, booed her! Now I don’t think that she would repeat it, even if some of us would be standing behind her and would be supporting her. I don’t think that she would dare to bring it out because of the humiliation she experienced. My point is: Who, of the people present there, was decent? Does one have dignity when one annihilates others’ efforts? Are we still talking about dignity or about the hegemony of a perceived normality?”

(Source: Report from a focus group discussion, facilitated by a local researcher, Theoneste Rutayisire)

Phases of sociotherapy

In the sociotherapy approach tailored to victims of war and political violence, the principles and practical-technical rules distinguished by Bierenbroodspot (see above)³ are applied in six phases, each having its own focus: safety, trust, care, respect, rules, and memories.

Safety. The goal of the safety phase is to explore what is going on in the ‘interpersonal space’, to create an atmosphere in which people feel safe, and start developing group cohesion. The exercises can be categorized as emotionally
binding. A practical example is an exercise lasting three hours, during which participants are guided methodically in developing their own code of group conduct.

**Trust.** Loss of trust in others and in institutions is a main consequence of exposure to serious traumatic events. To rebuild trust, a facilitator needs close cognitive and social-emotional attention, as well as care for the individual in the group. Creative and enjoyable listening exercises can be used and dialogue and decision making be trained, while the lead in sessions is given to the participants, and the group practices to comply to its own code of conduct. Basic concepts of group functioning can be taught. As it is key that a facilitator hands over responsibility to the group, this phase requires commitment, risk-taking and balancing skills.

**Care.** Care—in the sense of being cared for, self-care, and caring for others—includes mutual acknowledgement. In this phase of sociotherapy, sympathies for individual group members develop in each participant, and the group acts as 'a carrier of social events'. A facilitator now observes how group dynamics, the tension caused by togetherness, and different values, norms, expectations, and positive and negative experiences are dealt with. An example of an exercise in this phase is a discussion on the experience of social rejection. Subgroups can share examples of the experience of social disintegration during past violence, and subsequently enact these in plenary role plays. In a next step, emotions evoked by attention and care versus neglect and rejection can be explored.

**Respect.** In this phase, the focus is on the need of survivors of systematic violence to repeatedly test the other person's reliability and the degree of respect and acknowledgement encountered. Showing awareness and knowledge of the variety of factors making up the context of the violence that someone has experienced, may make this person feel respected. Facilitating and safely streamlining a social-political discussion may contribute to recognition experienced by group participants. Apart from group discussions, role plays are effective instruments in this phase. Games played can be used to exercise the safeguarding of rules.

**Rules.** Now, rules of different social systems are questioned. Thereby, feelings of autonomy as well as a future perspective are promoted. As a practical example, a group may compare rules of the existing social systems in their society with their own code of conduct or the sociotherapy principles learned. A group may also reflect on the rules and decision-making practices within the basic groups they belong to, such as families, schools and associations.

**Memories.** Processing traumatic memories is not an objective of sociotherapy, but memorizing traumatic events during group sessions may be unavoidable for participants. If safety, trust, care, respect and rulemaking have been established.
within a group, participants may share such memories and experiences. In such cases, a facilitator carefully tries to contain the emotional level and to prevent participants from being overwhelmed.

The idea of sociotherapy in Byumba

Seven church denominations have traditionally been represented in Byumba province. More have come into the area after the war and genocide. Like in the rest of Rwanda, the majority of the Byumba population considers itself to be Christian. Five percent of the population is Muslim. After the violent period in 1994, the EER Byumba Diocese realized that community-based psychosocial, educational and microfinancial support was needed. It started to support the population of Byumba province, not discriminating on religious or ethnic grounds, through a holistic set of spiritual and socioeconomic development strategies.

The idea of applying sociotherapy at a community level originates from discussions between a sociotherapist from Equator Foundation, her travel companion (an anthropologist), and an EER Byumba pastor in Rwanda in 2004. As expressed by this pastor, counselling was only moderately successful in helping people to recover from the suffering caused by mass violence in the past. Short training sessions in trauma counselling as offered occasionally to staff members of the Diocese, were never followed up in terms of setting up a counselling or treatment program. Such programs operated mainly in the capital city of Kigali, and hardly reached rural areas like Byumba province. Sociotherapy seemed to be a possible solution for this lack of (semi-)professional support, if implementation at community level (instead of clinical settings) would be feasible.

While embracing the sociotherapy approach in the past century, the European movement supporting the concept of therapeutic communities had furthered the idea that “a community created in the ‘reverse image’ of a society at large can be therapeutic for the casualties of that society.” The situation of Byumba as described above obviously called for the reversal of key elements of it. Massive traumatization had severely affected the well-being of many individuals. Common life and valued institutions had largely been disrupted. The social fabric had been damaged; there was a rupture of social bonds, distrust of people and institutions, and destruction of previous sources of support. Consequently, the misery had especially affected the population as a community, rather than only as individuals, even though each person inevitably processed the effects in his or her own way.

It is often postulated that justice and reconciliation can reduce people’s
suffering. In postgenocide Rwanda, so-called gacaca processes (a modernized form of traditional Rwandan conflict resolution) were installed to contribute to justice, healing and reconciliation. Like other institutions, the legal system was also basically destroyed during the genocide. Most of Rwandan judges and lawyers had either fled or been killed. It was estimated that it would take more than hundred years to judge all perpetrators of the genocide. The lack of security experienced in the recent past, however, caused the population to also distrust interventions aimed at justice and reconciliation. In addition, next to positive results, the gacaca processes also contributed to new societal tensions. Victims and perpetrators were confronted with each other; past painful experiences were recalled, potentially causing re-traumatization; some of the victims were more or less forced to testify, while being afraid of repercussions by the accused; and sometimes, innocent people were falsely accused and imprisoned. Analogous to the seeming impracticability of judging so many perpetrators, it would take decades to provide individual psychological support for all Rwandans traumatized by the war. The combination of omnipresent mental health problems and social disruption called for the introduction of a community-based approach that could reach a substantial number of people within a relatively short period of time, and with a minimum of financial means. Educating people to apply such approach would also contribute to the building of human capital. An additional reason for such an approach was that it might accomplish what gacaca in many cases failed to accomplish, i.e. reconciliation.

The experiences with sociotherapy in Europe as described above, showed its capacity to contribute to feelings of safety, trust, care and respect, and to help increase the self-supporting capacity of individuals and groups. Also, the approach appeared to be applicable for participants with a wide variety of cultural backgrounds. Therefore, when searching for a community-based approach, sociotherapy seemed to be a proper intervention method for a community-level program in Rwanda.

Development of the program

Recruitment of staff and trainees

The implementing organization, EER Byumba, appointed a local program coordinator and a secretary as staff members for the sociotherapy program. The Diocese also developed recruitment criteria for the first group of thirty-two people to be trained as group facilitators. These criteria were: emotional stability and proven trustworthiness; ability to reflect and eagerness to learn; receptivity to, and an understanding of the suffering of others; preparedness to
participate as a volunteer in the training; potential to transfer the knowledge, skills and experiences gained during the training; and willingness to voluntarily act as a facilitator for a 3-year period. It was decided that there should be an equal number of men and women. Trainees were selected and seconded by seven different local churches and by two public organizations. Most of the trainees appeared to have a secondary school level education. Some had enjoyed higher education and were working as teachers, priests or pastors, leaders of local government councils, civil servants, or staff of other non-governmental organizations (NGOs).

Training was provided by an experienced Dutch sociotherapist, who at the time was affiliated to both the Equator Foundation in Amsterdam and the Leiden University of Applied Science in the Netherlands. Over a period of 8 weeks, 32 volunteers were trained in 2 groups of 16 each. Subsequently, these 32 recruited another group of 75 volunteers, which they themselves trained for 2 days a week over a period of 4 weeks.

Manual development
The expatriate trainer’s daily reports, together with the training programs developed later by the first group of 32 local facilitators, formed the basis for the development of a sociotherapy manual for field use. The manual was written in the local language (Kinyarwanda) by the secretary of the program and a local translator who had been involved in the training. In the field, the facilitators used their own notes made during the training, which added to the local ownership of the program.

Entry criteria
With and among the first group of trained group facilitators, it was extensively discussed whether certain criteria, such as belonging to an identified ‘vulnerable group’ (see above), should be applied for entering sociotherapy groups. No agreement was reached on any criterion. Finally, there was unanimous consent that no entry criteria for group participation should be applied. There were various reasons for this decision: 1) It was generally felt that all Rwandans, including program staff and facilitators, had suffered from the past violence and its consequences. For example, the 32 trainees collectively had lost 365 close relatives and 1295 friends, classmates, neighbours, or colleagues. Applying entry criteria would automatically mean the exclusion of others, which was considered as highly undesired; 2) When selecting individuals, these people would run the risk of being stigmatized; 3) Community cohesion would benefit most from
sociotherapy groups that represented a cross-section of the population; 4) A group with too many problems might be too hard to deal with for beginning facilitators. In due course, having received additional training and having gained experience, facilitators might be able to handle more complicated cases.

**Incentives**
The initial plan was to have 1 full-day session per week, which might necessitate the provision of drinks and food. The issue generated different opinions and emotions among program staff and facilitators. After the Bishop of EER Byumba had expressed his view that providing reimbursement would not help break the circle of victimhood and dependency, go against the core idea of sociotherapy and mean “the end of the program,” the length of the sessions was set at 3 hours per week. No material incentives for participation would be provided.

**Implementation**
During the first series of sessions, 45 pairs of ex-trainees facilitated groups of around 10 participants each. It was also allowed to work with smaller groups. Though larger groups were discouraged, they frequently practiced. Groups were started in urban as well as rural settings. Age was not used as a selection criterion, although no persons younger than 16 years of age participated. Groups would meet 15 times, after which new participants were given an opportunity to join. It turned out that many were eager to join. Also, participants started to stay together after the end of the sessions. After 15 weeks, separation often proved to be emotionally difficult for both participants and facilitators. Self-financed farewell ceremonies and aftercare meetings with facilitators gradually became common practice. Many groups took the initiative to save money to support individual members, or to start income-generating associations. Over the course of 2 years, groups were composed of ex-prisoners, widows, orphans, HIV/AIDS affected people, single mothers, secondary school students, mixed groups, and groups of a cross-section of men, to be followed by a group of their wives.

**Follow-up training**
Two program staff members and the members of the so-called Leading Team (5 facilitators democratically elected by their peers) received further training in capacity building and program management. The first group of 32 facilitators was given additional training in sociotherapy and group dynamics. In 2008, all participated in an exam testing their knowledge and skills. It consisted of an oral part, a written contribution to a book on sociotherapy in Byumba, and a
contribution to a local symposium where the range of sociotherapy methods was presented. All facilitators that had passed that exam received a certificate testifying that the owner had fulfilled part of the requirements for a higher vocational education degree.

Reception of the program
Stakeholders of the program were the EER, trainees, facilitators, beneficiaries (including group participants’ relatives, friends and neighbors), local authorities, and the donor (Dutch development organization Cordaid). All responded positively to the content of the program and its results. However, as Lees et al. put it: “The question ‘how does it work?’ is still unanswered, since it is difficult to tease out the mechanisms at work inside such a complex and multi-faceted treatment as a therapeutic community.”\textsuperscript{10} This also applied to the Byumba program. Therefore, a scientific research project with qualitative and quantitative elements was carried out to determine what made it work, and what its impact was in terms of improving the mental health, social functioning and social capital of its participants. Outcomes from the qualitative studies in question have been published by Richters et al.\textsuperscript{11,12} Chapters 6 and 7 of this thesis present some outcomes of the quantitative part of this research; other results have been or will be published by Verduin et al.\textsuperscript{13,14}

Participants
Based on comments given and a participation rate of 87.5%, it may be concluded there was a general appreciation of the sociotherapeutic approach among the 3,700 people that took part in the program between January 2006 and April 2008. Over this period, facilitators provided weekly sociotherapy sessions to 45 to 60 groups.

Group participants practiced and discussed what they gained from sociotherapy at home and in their immediate environment. When asked what sociotherapy is, a woman who had lost nine children said: “I had completely isolated myself, until the facilitators invited me into a group. The other women in this group helped me to handle my current life situation. These women are my new family. Sociotherapy for me means respect, togetherness and a new family.” A 30-year old man said: “Since I was released from prison, life has been very hard. Everyone looks down on me. In this sociotherapy group I am treated as a person of full value, I count as a human being and not just as prisoner number x. In the future I want to stay part of this group.” The issues most frequently discussed during sessions were poverty, war and genocide, gacaca, domestic problems,
land conflict, social conflict, social reintegration, education, health, poisoning, polygamy, suicide and worries about the future.

Vignette

The following excerpt of the report of a sociotherapy session illustrates the evolvement of a discussion in this group.

“It all began when Celestin mentioned equality as an advantage of closed families, just as other points had been listed. But as soon as he said it, Laurent raised his hand to object and said: ‘What do you mean by equality? There is no way that a man can be equal to his wife, I don’t believe that, it is not possible.’ Knowing what he had said in the previous meetings, I (the researcher) chipped in and asked him what he himself understood by ‘gender equality.’ He replied by saying: ‘The way I understand equality is like today my wife has cooked the meals, made the bed and cleaned the house and tomorrow she says it is your turn to do what I did yesterday because we are equal now. But that is wrong. I cannot accept it, because as a man, I know my task is to cut firewood, farm, etc. I will not ask my wife to take on those tasks, she knows hers and I know mine.’ As soon as he had said that, Francois raised his hands to differ with him. He said: ‘I don’t agree with you, because first of all you don’t understand what equality is about, it is not about tasks at home, it is about being equal before the law, the way we all are equal before God.’ When he mentioned God, Laurent smiled and said: ‘I am glad you are bringing up God. When you read the Bible you better do it well. In the Bible it is clear God created woman out of the limb of a man, so how can they be equal?’ But Francois was not convinced and he gave an example of what happened in his family: ‘My Dad was rich, we had a good number of goats and cows, but when the time came for us to go to school, my Dad only sent us boys and left our sister at home to look after the animals. He used to say: “What else would a girl do apart from looking after animals?” And he said: ‘You all know it, my Dad was a wealthy person, and this is what I mean. Had he known that we are equal, he would have let our sister go to school like us.’ At this point I (the researcher) noticed that the participants took over the lead completely and we, the facilitators, sat there just watching how they exchanged views (meaning that they felt safe and self-confident).”

(Source: Byumba sociotherapy research report by Theoneste Rutayisire. The participants’ names have been changed to ensure anonymity.)
Facilitators
Out of the 107 trained facilitators, 13 left the program, for valid reasons: finding a full-time job, moving house due to heritage of land, or marriage elsewhere. Facilitators worked on a voluntary basis, but were given small incentives, food and travel fees. While working in couples, their individual attendance rate was 84%. They appeared to be motivated by: the positive impact of sessions on themselves; to help bear the suffering of Rwanda; receiving a certificate after performance; receiving additional training that enabled them to support the start of income-generating associations.

Local authorities
The sociotherapy program had not only been requested for, but was also supported by Byumba authorities, who were involved from the start of the program. Local leaders noticed positive effects. One female leader said about widows who participated in sociotherapy groups: “Before, I considered them as pitiful outcasts, as they did not collaborate with others in common activities, arguing they were too poor. But today they look smart; they wear clean clothes, attend meetings, participate in many activities, and operate in agricultural associations.” The EER Bishop noted in 2006 that the sociotherapy program socialized people. The headmaster of a secondary school said: “Neighbors, friends and colleagues visited each other after the war and genocide. Those meetings were always formal and aloof in character. We used to keep things inside. The sociotherapy method invites our people to meet in another way. It enables them to share daily worries and reflect on the painful past in a safe way. This is highly appreciated.” A specific expression of the appreciation of sociotherapy was its integration in the poverty eradication program of what was previously the Kisaro District in Byumba Province.

Vignette
“Shortly after sociotherapy came to Byumba, it elicited many different reactions, some of which expressed appreciation. Group facilitators appreciated the approach because it showed so many similarities with what was common in their culture. Others—from the training team to participants of sociotherapy groups—were amazed, wondering how it was possible for people to become friends and trust each other in such a short period of time! Some even wondered how people could easily become like members of one family. (...) While asking myself these
and many others questions, it came to me that this sociotherapy method is a kind of gacaca system. (...) However, in sociotherapy there is democracy; everyone has the full right to express himself, and conclusions are only drawn when there is consensus within the group. In the traditional gacaca the population only had a limited say. The last words were reserved for the committee of the people with integrity.”

(Source: Pastor Emmanuel Ngendahayo, coordinator Byumba Sociotherapy Program)

The donor
In April 2006, upon the first positive responses to the sociotherapy program, the Dutch donor agency Cordaid encouraged the organization of a national workshop in Rwanda’s capital Kigali, under the heading: ‘The role of sociotherapy in community healing’. Representatives of different local NGOs, authorities, local organizations, universities, and the Rwandan Ministry of Health attended the workshop, together with delegates from Burundi, Uganda, DR Congo, and the Netherlands. Similarities and differences between various approaches in trauma healing, psychosocial support and reconciliation were discussed. The impact of the Byumba program was acknowledged, and delegates identified the method as valuable and potentially complementary to other interventions in the field. In particular, the program’s capacity to provide care to many within a limited period of time was appreciated. The delegates indicated they considered sociotherapy as a potentially relevant method for the whole Great Lake region. After the positive reception of the Byumba program, Cordaid agreed to proceed with it. Subsequently, it was explored if, and what kind of, body-oriented therapy might be an appropriate addition to the sociotherapy approach. Supervision for facilitators, expansion the program within Byumba province, and the development of another program in Nyangezi, DR Congo, were allowed. This latter program started in September 2007 with a first training. Field implementation followed in January 2008. Later, a third program was implemented in Nyamata, Rwanda.
**Challenges**

Major success factors of the sociotherapy program in Byumba have been the commitment of its staff and group facilitators, the active support of the EER Byumba, and the careful way the program was embedded in local structures and adapted to local culture. Challenges remain, however, as will be discussed below. Both facilitators and participants have made various demands for an extension of the program: to raise the number of group sessions; provide after-care for the beneficiaries; differentiate and add treatment methods; support income-generating activities; expand activities to other areas. Taken together, these demands were too much for the program to carry. It would require more coordination and more financial funding, which was not available. Although facilitators themselves urged to be allowed to give more support to the beneficiaries they were confronted with, this would exceed their capacities. However, it was obvious that for certain participants sociotherapy did not suffice to help alleviate the most serious trauma-related symptoms. There was a frequent call for individual trauma-focused counselling or psychotherapy. One may argue that individual psychological care provision could work against sociotherapy in its striving for social bonding, and that it could prevent beneficiaries from sharing issues within a sociotherapy group. Still, if resources would be available, an individual support offer to those with serious complaints which persisted despite support through sociotherapy, could meet existing psychological health needs. Such an addition would complement the program in a way consistent with the widely embraced IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.\(^\text{15}\)

Any new initiative needs the time and the opportunity to mature, and so did the Byumba sociotherapy program. Training, supervision and emotional support for the facilitators need ongoing attention. Also, proper steering of a larger and more complicated, multidisciplinary program requires investment in the development of the management skills of the program staff. Unfortunately, while in a period of economic adversity, when NGOs are struggling for survival and governmental bodies clearly set other priorities, major investments in programs such as the underlying are not be expected. The optimal situation would be the development of a differentiated support offer, combining community and focused psychosocial support with specialized mental health care, and with links to initiatives in related areas necessary for recovery, such as economy, justice and governance.
References