Measures and outcomes of a psychosocial group approach in Rwanda
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CHAPTER 1

GENERAL INTRODUCTION
Violent conflict has serious and prolonged mental health consequences\textsuperscript{1-6}. Post-emergency mental health interventions are mostly aimed at persons at risk of psychiatric disorder, particularly post-traumatic stress disorder (PTSD)\textsuperscript{7}. However, opinions differ regarding the value of such psychological trauma-focused care\textsuperscript{8}. As organized violence affects individuals as well as communities and social institutions, it is argued that mental health interventions should not only focus on internal psychological factors but also address aspects of the social environment which could promote healing and adaptation\textsuperscript{9}. Unlike trauma-focused approaches, psychosocial interventions focus primarily on stressful environmental conditions such as the division within communities, the destruction of social networks and the resulting loss of social and material support. Altering these conditions may foster people’s inherent capacity to recover\textsuperscript{10}, cause improvement in nonspecific symptoms among persons with and without specific disorders and, in some cases, be enough to reduce symptoms below the threshold of clinical disease\textsuperscript{11}. Psychosocial interventions are preferably implemented at population level and directed at groups rather than individuals. Group interventions have shown to have a positive impact on health outcomes in other areas of public health\textsuperscript{12,13}. In war-affected societies a particular objective may be the restoration of social connectedness and mutual support. There is little substantive discussion of comprehensive psychosocial interventions on humanitarian responses to disaster in the literature\textsuperscript{14}, and no controlled trials of such interventions exist. We carried out a longitudinal quasi-experimental study to assess the effect on mental health of a psychosocial intervention programme which makes use of a therapeutic group approach called sociotherapy.

**SOCIOTHERAPY**

Traumatized survivors of war or political violence often have complex problems, with anxiety (fear), depressive and cognitive disturbances. Most patients also suffer from feelings like shame, guilt, distrust and alienation (feeling a stranger among others). Such feelings complicate social functioning and interpersonal contacts in communities where social structures and cohesion have already been damaged by human violence. Psychological and behavioral problems hamper daily functioning and the engagement in relations. One specific manifestation of posttraumatic psychopathology for example is partner violence. Prevalence of partner violence is high in post-conflict settings\textsuperscript{15} and consistently associated with mental health problems.

It is highly relevant to learn how to cope with difficulties as mentioned above. This may not only counter individual suffering, it may also help to prevent additional damage in social relations caused by ongoing behavioral disturbances, and to rebuild meaningful social structures in which people can re-find and practice (self)respect.

Social capital is potentially a key resource supporting post-conflict recovery. The core contention of the concept of social capital is that social networks are a valuable asset, providing a basis for social cohesion and cooperation. Within networks, trust between individuals can yield trust between strangers, and trust of social institutions. Ultimately
it may become a shared set of values, expectations and behaviours\textsuperscript{16}. The more a social network is characterized by norms of trustworthiness and reciprocity, the greater the social capital represented. It then acts as the ‘glue’ that holds people and groups together and makes cooperative action possible. Promotion of social capital may impact post-conflict recovery both through increased social cohesion and through better mental health\textsuperscript{17}.

Sociotherapy, a group approach stemming from England during the Second World War\textsuperscript{18,19}, seemed to be an approach that could enhance social capital by creating meaningful social structures in which people can re-find and practice (self)respect. The method therapeutically uses interaction between individuals and their social environment to help subjects to re-assess and re-define values, norms, relations and possible collaborations. The principal premise is that reaching a certain level of mutual respect, trust and care in group interaction helps to increase the problem solving capacity and subjective mental health in individual group participants.

In sociotherapy with survivors of systematic violence, safety and the setting of democratic rules are additional primary objectives. Key elements of the working methods are debates and the exchange of experiences and coping strategies among participants, exercises, games and mutual practical support. The approach does not primarily aim at sharing or processing traumatic memories. Trauma symptoms are addressed through psycho-education and advice.

This thesis presents measures and outcomes of sociotherapy performed in a northern province in Rwanda, called Byumba (Gicumbi). Our study in Byumba adds to the evidence about the treatment of complex trauma-related psychopathology in non-western survivors of systematic human violence. Up to now, most treatment studies concerning psychological trauma relate to PTSD and/or depression and mainly focus on mental health. This project is innovative because it studies the effects of an intervention method that aims primarily at social bonding, while simultaneously aiming to improve general psychological well-being. It focuses on social and behavioral aspects, not on individual pathology.

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**Context of Byumba**

The former Byumba province is located in the north of Rwanda, bordering Uganda. The invasion by the Rwanda Patriotic Front (RPF) from Uganda into Rwanda on 1\textsuperscript{st} October 1990 started a civil war in the north of the country. Predominantly of Tutsi origin, many of the members of the RPF were second generation refugees who had fled to Uganda and settled there from 1959 onwards, escaping ethnic purges in Rwanda. The RPF went into Rwanda as an army of liberation but was perceived by the majority of the population as an army of occupation. The invasion led to massive displacements of people over the next few years to refugee camps further south. Low intensity fighting was interrupted by several massacres, including one in Byumba. During and after the 1994 genocide many people fled to refugee camps in neighbouring countries and stayed there for at least a few years.

The war (1990-1994) and genocide (1994) related problems affected men and women of all ages. The population experienced atrocities like killings, sexual violence, torture, intimidation, robbery, destruction of property, and social rejection, leaving the community in a state of trauma. A relatively large part of the population came to consist of widows, widowers, orphans, physically handicapped, prisoners and ex-prisoners\textsuperscript{18,20}. 
The combination of omnipresent mental health problems and social disruption in Byumba, Rwanda, justified the introduction of a community-based approach; community-based in the sense that it would be owned and carried out by members of the local population. Such an approach could reach a substantial number of people within a relatively short period of time, with a minimum of finances. Educating people to apply this approach would also contribute to the building of human capital.

With financial support from Cordaid, Equator Foundation was able to send one sociotherapist to train people as sociotherapists in Byumba, and later also in other parts of Rwanda and in DR Congo. Cordaid also enabled Equator to carry out a scientific evaluation of the sociotherapy programme in Byumba. This is a quantitative study; it was coordinated by the authors of this chapter, but it could not have been carried out without the aid of many Rwandan collaborators. The study is complementary to a qualitative study led by A. Richters18,20,22,23.

THE SOCIOThERAPY PROGRAM IN BYUMBA

The sociotherapy program in Byumba was set up in collaboration with the Episcopal Church of Rwanda (ECR), starting in 2005. Approval was given by regional and national authorities in Rwanda. Wide support on community level was gained through public acclamation by the ECR. Close collaboration with local staff, allowing local control and embracing local social manners and values were key to the programme’s viability. At first, 32 recruited volunteers were trained as sociotherapists in two groups of 16 each. These 32 people subsequently selected and trained another group of 75 trainees. In total they received a 3 months’ training from Equator staff.

The sociotherapy program was open to any adult (≥16 years) wanting to participate. Also, community members could personally be invited when considered psychosocial problem cases by sociotherapy group leaders. Groups contained 10 to 20 participants and were mostly mixed: both sexes, various ethnic backgrounds, wide age distribution. Forty-five groups ran simultaneously, having weekly meetings over a period of 15 weeks, lasting 3 hours each.

The sociotherapists worked in pairs and facilitated a group together. They were local people, familiar with the region’s history and current living situation. They were allowed to attune the working methods to the characteristics of their groups (e.g., degree of trust, nature of problems) and to their own affinity and experience, putting different emphases on elements like rules, role plays, and spirituality.

Most importantly, the groups were held in a private, undisturbed place, where all participants could sit down. As well as upholding democratic rules, men and women were treated equally, so were young and older people.

The program ran for 7 years. Over 10,000 individuals have participated in groups. It has been extremely well received and was highly appreciated by the local population. It was fully coordinated by the EER Byumba. Major success factors of the sociotherapy program in Byumba have been the commitment of the staff and facilitators of the program,
the active support of the Bishop of the EER Byumba at crucial moments, and the careful way the program has been embedded within the local structures and has been adapted to the local culture.

As we assumed that the intervention would impact people’s mental state, their daily functioning, the way they interact, undertake common actions and the way they feel connected to each other, we defined the areas of interest for this study as mental health, social functioning and social capital. It was also hypothesized that the intervention would have a positive influence on another manifestation of posttraumatic psychopathology: partner violence.

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<td>How qualitative information helped to shape quantitative research instruments in Rwanda.</td>
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<td>In search of links between social capital, mental health and sociotherapy: a longitudinal study in Rwanda.</td>
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Our main research question was:

*Does sociotherapy in a post-conflict setting impact mental health, social functioning and social capital?*

For this thesis we formulated three subquestions:

1. Method development: How do we measure mental health, social functioning and social capital in a Rwandan context. Can we show that our questionnaire is valid: that its outcomes really reflect mental health, social functioning and social capital, respectively? Chapters 2, 3 and 4 describe work on the validation of the instruments.

2. Outcome measures: What is the effect of sociotherapy on mental health and social functioning? Chapter 5 presents our study on the effect on mental health. We did not find a significant effect of the intervention on social functioning; this study outcome will be discussed in chapter 8, the general discussion. Chapter 6, however, does present data on partner violence - one manifestation of social functioning - in our sample. It provides prevalence data of partner violence and associations with mental health.

3. Mechanisms: If sociotherapy has a positive impact on mental health, is this because of change in social capital? Can we explain the mechanism for change in mental health? Chapter 7 presents relations between social capital and mental health.

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<th>Analytical approach</th>
<th>Sample</th>
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| Qualitative description | (Pilot study)  
N=18, cognitive validation |
| Descriptive analysis, scatter plots | All respondents at baseline (N=393) |
| Multigroup confirmatory factor analysis | (Pilot study)  
Baseline (N=418),  
Follow-up (N=230), subsample (N=99) |
| Linear mixed-effects model (repeated measures) | Matched selection, three measurements; experimental and control group (N=200) |
| Regression analysis | All married respondents at baseline (N=241) |
| Latent growth models | Matched selection, three measurements; experimental and control group (N=200) |
METHOD

During 2007 and 2008 we carried out a quantitative study on the impact of the socio-therapy program. Its design was based on experiences and lessons learned during a pilot study we conducted over 2005 and 2006. We used a quasi-experimental design. We compared data taken from respondents who had participated in sociotherapy groups (the experimental group) with data which, over the same period of time, were taken from comparable others living in the same region who had not participated in sociotherapy groups (the control group). Trained Rwandan staff carried out interviews with the same respondents at three different points in time: upon the start of the intervention, right after, and eight months after completion of the group intervention. Demographic data (sex, age, education level and socio-economic status) were documented at each interview.

The first three chapters of this thesis describe work on preparing and validating measuring instruments. The other three chapters present outcomes of our quasi-experimental study.
In the general discussion we integrate the various results from all chapters.
REFERENCES

