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Annemiek Richters, Cora Dekker & Willem F. Scholte

A community based sociotherapy programme was implemented in the North of Rwanda in 2005. This article describes the background of sociotherapy, explains its principles and application in therapy for refugees in the Netherlands, and gives a justification for the introduction of the approach in a particular setting in post war and post genocide Rwanda. It then focuses on the development of the programme in this setting and addresses recruitment criteria for facilitators. It includes the qualities these facilitators and programme staff should have, the training process, the programme implementation, as well as the sociotherapy methods applied in the field with some examples from practice, the reception by the various stakeholders and the expansion to other areas. The article ends with a selection of the many challenges the programme faces.

Keywords: Rwanda, Byumba, war, genocide, mental health, psychosocial, group therapy, sociotherapy, community based

Introduction

The Byumba Diocese of the Episcopal Church of Rwanda (EER; Eglise Episcopale au Rwanda) started a sociotherapy programme in the Byumba province[1] of Rwanda in September 2005. Its goal was to help people regain feelings of dignity and safety and to reduce mental and social distress in a situation where people are still highly affected by a history of war, which resulted in the 1994 genocide. After a training period of three 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, several of its stakeholders started to express their appreciation of the programme and its results. This led to the organization of a conference in January 2007 with the objectives to: 1) introduce the Byumba sociotherapy programme to practitioners and policy makers working in the area of mental health, trauma counselling, psychosocial care and reconciliation in Rwanda and its neighbouring countries; and 2) compare the sociotherapy method with other methods used in the fields mentioned. A result of this conference and subsequent exchanges with practitioners and policy makers led to an expansion of the sociotherapy activities to other areas of Byumba province, the introduction of a programme in South Kivu, Congo, and the preparation of programmes in other regions of Rwanda.

This article is written in response to the many requests of the Byumba programme staff, and us as consultants, to share the Byumba sociotherapy experience with 'the outside world'. We believe that after more than two years of practice in the field, the programme now is solid enough to meet these requests in the form of this article. Sociotherapy in Byumba first needed time to fully develop, to be understood by the people implementing it, to be adjusted to the local context and to root it in that context, as well as to prove that it had the desired positive impact on its target populations. It also had to be sustainable. In

what follows, we will describe the 'why','what' and 'how' of the programme, followed by a preliminary evaluation of what it has achieved thus far, with a view of future prospects.

Origins of the programme

During a short study visit to Rwanda in 2004 (Richters, Dekker, & de Jonge, 2005) the first two authors met pastor Emmanuel Ngendahayo of EER Byumba. He told us about the continuing suffering of the people in Byumba province as a consequence of the war and genocide in that area. In addition, he stressed the limited success of pastoral counselling in helping people in their recovery process and rebuilding their lives. Occasionally, he and other staff members of the Diocese followed short training sessions in trauma counselling. However, to his regret, there was never a follow up to these trainings in terms of setting up a trauma counselling or a treatment programme. Such programmes operated mainly in Kigali, the capital of Rwanda, and hardly reached rural areas, such as Byumba province. In response, Cora Dekker explained the methods she and her colleagues apply in a sociotherapy programme for traumatized refugees in a clinical setting in the Netherlands: Equator, the refugee unit of the department of psychiatry at the Academic Medical Centre of the University of Amsterdam. We discussed the question of whether sociotherapy, as offered to refugees in The Netherlands in a clinical setting, would also work in Rwanda. Since there were no trauma clinics in Rwanda, a community setting seemed the most appropriate to us for practicing sociotherapy.

Since the 1970s sociotherapy is part of the mental health care provision in the Netherlands. The psychiatrist Bierenbroodspot was a main instigator of this development. His work has roots in the work of British psychiatrists who laid the foundations of this approach during the Second World War, a time when society had to cope with many psychiatric casualties of war. Rapoport (1960) characterized the approach that had developed since that time as 'a community acting as a doctor'. Bierenbroodspot (1969) incorporated the basic assumptions, or principles, underlying sociotherapy (democracy, non-directivity, equality, a focus on reality, and an orientation to the future) into the following practical–technical guidelines:

1) two-way-communication at all levels – this communication is a precondition to warrant that everyone is informed about what goes on in the group and can use that information in decision-making;
2) decision-making at all levels – this promotes, among other things, sympathy within the group as a whole and with individual members;
3) shared leadership – this actually means democracy, the sharing of power and responsibility;
4) consensus in decision-making – when the group cannot come to an agreement, no decision is forced, but the discussion continues until consensus is reached;
5) social learning by social interaction here-and-now – this learning will also benefit group participants in their social interaction in the wider society.

Sociotherapy differs from psychotherapy in the sense that sociotherapy therapeutically uses the milieu – the totality of the clinical setting in which the listed principles and methods are applied – as a model that confronts a patient with his 'outside world'. This is the opposite of confronting a patient with his 'inside world' during psychotherapy (Bierenbroodspot, 1969).

Over the last decade, sociotherapy has been adapted for the treatment of refugees who had fled from political violence and were now residing in the Netherlands. This initially happened in Centrum '45 – a centre for the treatment of victims of persecution, war and violence. Later the work continued in Equator (see above). As the approach was to be applied 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, a confrontational conversation between group participants, although facilitated by a sociotherapist, might increase feelings of not being safe. Facilitators learned to take on a regulating role in the starting phase of group sessions, and to only slowly delegate responsibility, e.g. for decision making, to the participants. They also learned how to adapt to the social, political and cultural aspects of issues of proximity and distance, and to dissolve tensions in case of disrespectful treatment and enemy projections.

The idea to offer sociotherapy to people in post conflict countries was born in the Dutch refugee clinics. '*We wish our people at home had known this method before the conflicts erupted into violence*', was what clients expressed more than once to sociotherapists. Before explaining how sociotherapy was eventually introduced in the Byumba context, let us first focus on some of the characteristics of that context.

Byumba in context

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 lst 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, refusing to accept majority rule and to cooperate with Hutu power in Rwanda and 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, people fled to refugee camps in neighbouring countries and stayed there for several years (Mamdani, 2001).

The war (1990–1994) and the genocide (1994) the related problems of the war affected men, women and children of all ages. The population experienced ceaseless atrocities such as: killings, sexual violence, torture, intimidation, robbery, destruction of property and social rejection. This left the community in a state of severe trauma. As a result, by the end, a relatively large part of the population consisted of widows, widowers, orphans, the physically disabled, prisoners and ex-prisoners. Representatives of the Byumba Diocese told us, when discussing the sociotherapy programme proposal; '*there is a general feeling of insecurity, powerlessness and desperation among the population. Many people do not care about themselves any more. People lost their interest in dignity and do not care about the future. Some have become aggressive in reaction to everything, whether good or bad. Others are aimlessly wandering around without courage or a plan to survive*.'

The return of displaced persons and refugees after the genocide generated additional

problems relating to a complicated re-integration process. Within the population, which is suffering as a whole, categories of people can also be distinguished that are each, in their own way, vulnerable for specific reasons.

The first category is women. Almost 60 percent of the Byumba population is female. The two main reasons for this disproportion is that men were the main targets of the killings or are still in prison, leaving many non-widowed women alone. Life has been, and still is, harsh particularly for women. They have been exposed to violence, rape, and loss of family members and properties. For many women, education had stopped abruptly during the war and never started again. Many have had to live in refugee camps. After their return, widows sometimes had to find shelter with other families. All returning women and their surviving children (often accompanied by one or more adopted orphans) had to deal with a completely disrupted society. Some had to take over tasks of husbands and sons who were in prison. They may also have to feed those husbands and sons. Women are the heads and hearts of their family and work hard to keep the family going.

Another category is released prisoners who found, on return, that they had lost their jobs, properties and roles in society. Many experienced problems in their homes, e.g. wives who had brought another man into the home and may have given birth to another man's children. Female prisoners may have found their husbands married to another woman. The sudden release of groups of prisoners in 2003 also created an increased fear in society, which added to the ex-prisoners' burden to cope.

Orphans adopted by other families, whether blood-related or not, 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 started heading households themselves, thereby taking care of younger brothers or sisters without the necessary means to do so properly.

Other particularly vulnerable groups are single mothers, people living with HIV/AIDS, youngsters who are jobless, victims of domestic violence, and wives/widows in/of polygamous marriages.

Extreme poverty is one issue that cuts across all categories and affects the majority of people. The poverty percentage in Byumba province 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 post secondary education. Almost half of the adult population is illiterate. The percentage of people affected with HIV/AIDS is also above the country average.

The EER Byumba Diocese realized that community based psychosocial, educational and micro-financial support was needed to break the deadlock. It began to help the whole population of Byumba province, without discrimination based on religion or ethnicity, through a holistic set of spiritual and socio-economic development strategies. Seven Church denominations have traditionally been represented in the 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.

Reasons for introducing sociotherapy in Byumba

Sociotherapy in Europe has been practiced in group settings called therapeutic communities. The therapeutic community movement 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'* (Bloom, & Kingsley, 2004). The situation of Byumba as described above obviously called for the reversal of key elements of it. Massive traumatization has severely affected the well-being of many individuals. People lived in shock, and everyday life routines to cope with chaos had collapsed. Common life and valued institutions had largely been disrupted. Institutions, which had previously dealt with social chaos, had lost their legitimacy. The social fabric had been damaged, meaning that there was a rupture of social bonds, disconnectedness, distrust in people and in 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 post genocide 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 a hundred years to judge all perpetrators of the genocide. The lack of security experienced in the recent past, however, still causes the population to distrust interventions aimed at justice and reconciliation. Many still exhibit a continuous state of alertness. In addition, as well as 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 falsely accused, innocent people or husbands needed at home were 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. In many survivors, the loss of control over their own lives has caused feelings of great insecurity and powerlessness, and the burden often still continues. Psychological and behavioural problems hamper daily functioning and the engagement in relationships. Successful coping with these difficulties is highly relevant. This would not only counter individual suffering, it would also help to prevent additional damage to social relations caused by ongoing behavioural disturbances, as well as rebuild meaningful social structures in which people can re-find and practice (self) respect.

The combination of omnipresent mental health problems and social disruption justified the introduction of a community based approach; an approach that could reach a substantial number of people within a relatively short period of time, and with a minimum of finances. Educating people to apply such approach would also contribute to the building of human capital. An additional reason for such approach was be that it might be able to accomplish what *gacaca* in many cases has failed to do, 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, it seemed to be a suitable choice to apply sociotherapy at a community level in Rwanda.

Development of the programme

The initial idea was to deliver the requested sociotherapy to a group of local community leaders and let them to decide how to proceed from there. We wanted to avoid the pitfall of preparing and programming too much beforehand, since that does not agree with one of the principles of sociotherapy: to leave space for participants to give direction to the programming. We realized, however, that this kind of open, step-by step approach would not be acceptable to a donor, which was needed for financial support. A donor usually needs a well prepared, and preferably detailed, plan of a programme for the period of at least a year. This led us to decide to suggest a proposal with all the relevant details of the intended programme. It was well received by Cordaid, a Dutch development organization, which at the time had a local office in Rwanda. On this basis, the agency decided to fund the programme, including its scientific evaluation.

Recruitment of staff and trainees

EER Byumba, as the implementing organization, appointed a local programme coordinator and a secretary as staff members for the sociotherapy programme. The Diocese also developed recruitment criteria for the first group of 32 people to be trained as group facilitators. These criteria were: emotionally stable, with proven trustworthiness; having the ability to reflect and an eagerness to learn; understanding and receptivity to the suffering of others; a preparedness to participate as a volunteer in the training; having the potential to transfer the knowledge, skills and experiences gained during the training didactically to others; and a willingness to voluntarily act as a facilitator for a three 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 turned out to have a secondary school level education. Some had followed higher education and were working as teachers, priests or pastors, leaders of local government councils, civil servants, or staff of other nongovernmental organizations (NGOs).

The organization of the training

Training was provided by Cora Dekker (the second author of this article). She works as a sociotherapy facilitator at Equator in Amsterdam and as a lecturer at the Leiden University of Applied Science, in the Netherlands. A 3rd year Social Work student accompanied her from the same university. Over the first eight weeks, the 32 recruited volunteers were trained in two groups of 16 each. These groups would alternate the work: one week of training and one week dedicated to a homework assignment. The 32 subsequently selected, and trained, another group of 75 trainees for two days a week over four weeks.

Qualities of a trainer and group facilitator

Facilitating a group of trainees and facilitating a sociotherapy (referred to as a socio group hereafter) is in many ways similar. In both cases a facilitator needs to be an open-minded observer of group processes and a listener to both what is being said, and not said, in these processes. This is in order to act in a

methodically effective manner, to gradually question daily social norms that limit participants' space and to apply appropriate and didactical forms. What a facilitator of every beginning group should observe is the *inter-est*, what people do with the space between them. How do participants in (new) groups handle the ordinary tension of being together, sharing the same space? How do they deal with their different values, norms, expectations, as well as positive and negative experiences? (Remmerswaal, 2006).

What happens in the first phase of a group process depends very much on the facilitator's sensitivity and skill in handling fragile social relations. This, combined with the potential social power of a given group, determines the development, dynamics and effectiveness of a training or socio group. According to de Vries (2000), 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. Questions to answer are: Is what is observed perceived as normal for/in the particular post conflict situation? How do people who have been exposed to extreme forms of political violence cope with and share the same space?

Application of the principles in phases

The sociotherapy principles and practical-technical guidelines distinguished by Bierenbroodspot (see above) were introduced into the Byumba training in phases, i.e. the phases of safety, trust, care, respect, rules and memories.

Safety. The goal of the safety phase is to explore what is going on in '*the space in between*', to create an atmosphere in which people will feel safe, and to start developing group cohesion. The training applied can be categorized as emotionally binding.

Vignette 1

The following quote from a facilitator, explaining what dignity means in the context of sociotherapy, illustrates the attitude a facilitator should exhibit: knowledge of the social context, an open mind, the ability to question social norms, and not imposing his/her own view.

'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 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 of dignity or about hegemony to set normality?'

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

During the first day in Byumba, for example, the trainees were methodically guided to develop their own code of group conduct. This exercise lasted about three hours. In such an exercise, all principles of sociotherapy converge.

Trust. Loss of trust in others and in institutions is one of the consequences of exposure to serious traumatic events (see above). To rebuild trust in '*the space in between*', cognitive and social-emotional attention, as well as care for the individual in the group, is required. It is crucial for a facilitator to check, by use of observational indicators, if the trust phase has been processed sufficiently. A hurried proceeding to the next phase of the training will be detrimental to the intended recovery processes. During the trust phase, a facilitator runs the risk of paying lip service to sociotherapy principles while remaining focussed on the individual level, and therefore not really handing over responsibility to the group. The phase requires commitment, risk-taking and balancing skills from a facilitator. In Byumba, creative and enjoyable listening exercises were used, and dialogue and decision making were included. The lead in the sessions was given to the participants. Basic concepts of group functioning were taught, and the group practiced complying with their own code of conduct. Group facilitators agreed, in a focus group discussion held one year after practice in the field, that safety and trust were the backbone of the sociotherapy method.

Care. Care – in the sense of being cared for, self-care, and caring for others – includes mutual recognition. In this stage of sociotherapy, sympathies for individual group members develop in each participant. Dynamics in the group come alive. The group now acts as '*a carrier of social events*', as Remmerswaal (2006) calls it. A facilitator at this stage has to observe how participants handle the developing group dynamics, the tension of being together and sharing the same space, and how participants deal with their different values, norms, expectations, and positive and negative experiences. Obviously, facilitators themselves are not excluded from feelings. Hence a pitfall here is that they may allow more proximity to some trainees than to others. In Byumba, this care phase was introduced by giving examples of how refugees in the Netherlands asked for recognition. The question was asked whether the feelings accompanying the experience of not being recognized were also known here. In subgroups, examples of the experience of social disintegration during past violence were shared and subsequently enacted in plenary role plays. The concepts of being cared for, self care and caring for others came alive and was practiced in the group. The next step, during the application of this mixed cognitive and social–emotional method, was to explore emotions evoked by attention and care, or neglect and rejection.

Respect. For a facilitator, it is extremely relevant to know and understand the variety of factors making up the context of the violence that group members have experienced. This helps in observing, understanding and addressing participants' reliability testing, a phenomenon continuously encountered in groups in Dutch refugee clinics. Refugees repeatedly tested the commitment, competence and genuineness of the facilitator in different ways. A facilitator's ability to safely streamline a social–political discussion often contributes to a feeling of recognition in a group. In this phase, a key question group members ask themselves is: '*Is the other person really respecting me, even after I explain what happened to me*?' In addressing that question, attention also has to be given to the difference in meaning of formal and

informal respect. The best intentions of facilitators to help can also be their blind spot: remaining too long at one level of a group process is as much a pitfall as a hurried proceeding. Also, listening to how violence affected communities and individual lives can be difficult for facilitators. Given our experiences in the Netherlands, respect was given full attention in the Byumba training. The horror of mass killings and humiliations in Rwanda deeply disrupted the sense of general and self respect of many people, since '*they were performed by hundreds of thousands of ordinary citizens, including even judges, human rights activists, and doctors, nurses, priests, friends and spouses of the victims*,' (Mamdani, 2001). Training methods in this phase included group discussions, role plays and games, as well as safeguarding compliance to the rules of the games and to the group's own code of conduct.

Rules. Having achieved a certain degree of satisfaction in the aforementioned phases, both facilitators and trainees started to question rules of different social systems; this indicates increased feelings of autonomy as well as the development of a future perspective. In this phase in Byumba, the expatriate facilitator asked the 32 trainees to compare rules of the existing social systems in their society with the self developed code of conduct and the sociotherapy principles they had learned. Particular attention was paid to reflection of the rules and decision making practices within the basic groups (such as families, schools and associations) that they belong to.

Memories. Memorizing traumatic events and experiencing the emotions linked to these events, may be destabilizing, but are also unavoidable in the process. Facilitators should be aware of the emotions that can arise when memorizing traumatic events, and how the impact can be overwhelming. They should be familiar with (the relevance of) carefully processing such emotions. After safety, trust, care, respect and rulemaking have sufficiently been established, participants are better prepared to concentrate on, and choose for, a therapy focusing on (overwhelming) emotions. In Byumba, memories and linked emotions were present during the whole period of training, and were verbally and nonverbally recognized. It was explained that a different kind of therapy would be appropriate to completely process painful memories and the accompanying emotions.

Integration. The last week of the 8 week training period was used to focus on integrating all the principles, phases and methods the training had covered. This helped the trainees to realize that they had developed the abilities needed to prepare for the next phases of their work.

Training of 75 additional facilitators

In pairs, all 32 trainees were guided in making a plan for the training of five new trainees per pair. The plan should include content of the training, methods to be used, material needs, a budget, and a meeting space for the training. Each plan was submitted to the other pairs for approval. The training plans reflected what had been understood, appreciated and prioritised as important from the past 8 weeks training. The trainees were given the assignment to define recruitment criteria for the 75 additional people to be trained. They came up with, more or less, the same recruitment criteria as EER had previously developed for their own group, with the addition of: having at least some years of secondary school education. The trainings were given in rooms in schools, churches and community buildings, or under a tree; all places where people would feel safe.

Manual development

The daily reports of the training, written by the expatriate trainer, together with the 16 training programmes developed later by the 32 trainees themselves, formed the basis for the development of a sociotherapy manual to be used in the field. The manual was written in the local language (*Kinyarwanda*) by the secretary of the programme and one of the two people who acted as translators during the training. They also used their own notes made during the training. This way of working contributed to the local ownership of the programme and the language used for it.

Preparation for implementation

The question of the target group to deliver sociotherapy had been a theme of discussion from the start of the proposal development through the implementation of the programme in the field. Target groups of vulnerable people, such as widows, had been identified, but how would inexperienced facilitators identify potential participants among these target groups? What indicators would be used, and how to carry out a selection process? This issue was discussed extensively with the first group of trainees, without any tangible results. The only point everyone strongly agreed on was that it would not be wise if groups would exclusively comprise people unable to handle their emotional problems. One of the trainees said; '*that will openly stigmatize people as weak and that is a risk we cannot expose people to*'. From that point onwards the expatriate facilitator advised the programme staff and the trainees to start groups with people like themselves. Everyone in Rwanda, including staff and facilitators, had suffered from the past political violence and its consequences. For example, the 32 trainees collectively had lost 365 close relatives and 1295 close friends, classmates, neighbours, and colleagues. There were several reasons to adopt the facilitator's view. First, group consensus had to be respected. Second, too problematic a socio group might be too hard to deal with for beginning facilitators. Third, a community's cohesion would be furthered most if groups represented a cross-section of the population. Fourth, applying inclusion criteria would automatically mean the exclusion of others, which was considered a highly undesired effect locally. And finally, with more experience and additional future training, the facilitators would learn how to handle complicated cases in due course.

Another difficult issue to solve was whether food or money should be provided to the socio group participants. The initial plan was to have one full day session per week, which might necessitate the provision of drinks and food. The issue generated different opinions and emotions among staff and facilitators. Not a penny had been budgeted for this provision. Finally the Bishop of EER Byumba was asked for advice. '*Providing food or money is the end of this programme*', was his short and clear response. His question to those with another opinion was; '*Are you convinced of sociotherapy's problem definition and its method?*' What was at stake here touched the core of sociotherapy. Giving in to an appeal for the satisfaction of the requested material needs would not help breaking the circle of victimhood and dependency. It would bypass the goal of sociotherapy, which first of all is to restore people's dignity and create connectedness. Like the Rwandan proverb says: '*Those who are joined together can carry an elephant with their hands*.' After the advice from the Bishop, the length of sessions was set to three

hours per week. No material reimbursement 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 have fewer than 10 participants per group. Working with larger numbers was discouraged, but practiced in many groups. Groups were started in urban as well as rural settings. Over the course of two years, groups were composed of ex-prisoners, widows, orphans, HIV/AIDS affected people, single mothers, secondary school students, mixed groups, groups of a cross-section of men, to be followed by a group of their wives. Age was not used as a selection criterion.

It was decided that each group would meet 15 times. It was just a guess made during proposal development, that for most participants this would be an appropriate duration to allow for regaining feelings of safety and trust. After 15 weeks, new participants were to be given an opportunity to join. It turned out that many were eager to join very soon. Also, instead of expecting food or money, participants started to stay together after the end of the sessions. Many groups took the initiative to save money to support individual members, or to start income generating associations.

The Byumba experience differs greatly from what the first two authors were told in 2004 by a trauma counsellor; *'participants think that trauma is something like malaria for which tablets exist. When the symptoms do not disappear, they don't return after three sessions,'* (Richters et al., 2005). In Byumba, separation after 15 weeks proved to be emotionally difficult for both participants and facilitators. Self-financed farewell ceremonies and after-care meetings with facilitators gradually became common practice.

Follow-up training

The two programme staff members and the members of the so-called Leading Team (five facilitators democratically elected from their peers) received further training in capacity building and programme management. The first group of 32 facilitators was given additional training in order to deepen their understanding of the basics of sociotherapy and learn more about *'group dynamics'*. Between May and August 2008, they will all participate in an exam to test their knowledge and skills. The exam will consist of an oral part, a written contribution to a book on sociotherapy in Byumba, and a contribution to a local symposium in which the range of sociotherapy methods will be presented. The certificate will testify that the owner has fulfilled part of the requirements for a higher vocational education degree. The idea is that this certificate will allow for future opportunities for sociotherapy facilitators to contribute to social healing, also in other post conflict areas in the Great Lake Region.

Reception of the programme

Stakeholders of the programme were the EER, trainees, facilitators, beneficiaries (including group participants' relatives, friends and neighbours), local authorities, and the donor Cordaid. They all responded positively to the content of the programme and its results. Lees, Manning & Rwalings (2004) write about therapeutic communities in general; *'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'*. This also applies to the Byumba programme.

Vignette 2

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", he continued, "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/sociotherapist) 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 in 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 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 there were two things I (the researcher/sociotherapist) noticed. First, the participants took over the lead completely and we, the facilitators, sat there just watching how they exchanged views (meaning that they were feeling safe and self-confident). Secondly, beneficiaries gradually started to use "I" referring to their homes or families.

(Source: Byumba sociotherapy research report by Theoneste Rutayisire of the 5th session of a sociotherapy group of men. The real names of the participants' have not been used above to ensure anonymity.)

Therefore, a scientific research project, also funded by Cordaid, with qualitative and quantitative elements is being carried out to determine what makes it work, and what is its impact in terms of improving the mental health, social functioning and social capital of its participants and their immediate surroundings. For this study local university students, sociotherapists, a psychologist and a theologian (who acted as translator during the training periods) were trained to carry out research tasks. In this way, the programme also contributes to research capacity building. In this article only some indications of the programme's effects can be presented. Scientific outcomes will be published in the near future.

Participants

Based on comments given and a participation rate of 87.5%, it seems there was a general

appreciation of the sociotherapeutic approach among the 3700 programme participants between January 2006 and April 2008. During this period, facilitators (in pairs) provided weekly sociotherapy sessions to 45 to 60 groups of about 10 participants each, for a period of 15 weeks.

What group participants gained from sociotherapy was practiced and talked about at home and in one's immediate environment. That means that we can multiply the effect of the sociotherapy provided to the 3700 *'directly exposed'* participants with a number of minimally five. This equals a number of 18 000 local people having experienced some impact.

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 is respect, togetherness and a new family.'*

In a group of ex-prisoners we raised the question; *'what touched you most in sociotherapy?'* A 30-year old man avoiding eye contact answered; *'since I was released from prison, life has been very hard. Everyone looks down on me. In this socio 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.'* Another ex-prisoner said that he was 78 years old, and unable to read and write. Without any hesitation he replied; *'with the sociotherapy method I decolonized myself. In this group, we talked about the thoughts that had colonized me for a long time. I have rejected them and this is much better.'*

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.

Facilitators

Out of the 107 trained facilitators, 13 left the programme, for valid reasons: finding a full time job, moving house due to heritage of land, and marriage elsewhere. Facilitators worked on a voluntary basis, but were given small incentives, food and travel fees. The attendance rate in the groups was 84%.

Facilitators expressed through various statements that *'sociotherapy helps us to share the Rwandan burden.'* It is most likely that another motivational factor to stay involved is that *'sociotherapy helped me a lot.'* The first group of 32 facilitators may also have been motivated by the fact that they would receive a certificate if they performed well (see above). Yet another motivation was sociotherapy's capacity to provide a future perspective to participants: an additional course enabled facilitators to assist participants in organizing themselves after 15 sociotherapy sessions into formal associations for the execution of income-generating activities.

Towards the end of 2006, extension of the programme began to the areas characterized as more difficult, referring to the complex history of political violence in the area. This was quite a venture. As one staff member put it: *'when sociotherapy works there, it works everywhere.'* So far sociotherapy sociotherapy delivered in these areas has also been received quite well.

Local authorities

New initiatives often have better perspectives when supported by existing organizations. The sociotherapy programme had not only been requested for, but was also supported by Byumba authorities, which have been involved from the start of the programme. Local leaders noticed positive effects. One female leader, for instance, said about widows who participated in socio 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 are smart; they wear clean clothes, attend meetings, participate in many activities, and operate in associations in order to cultivate. You find that they broke out of isolation.'

Bishop Rwaje of the EER noted in 2006; '*this approach is socializing our people, the principles seem to match with principles guiding Rwandan life.*' Comparisons have been made with other trauma reduction efforts and the so-called '*biblical approach*' over the last 10 years. '*Trauma counselling felt as if it was judging us, and the Christian approach as blaming us. Sociotherapy is without judging or blaming anyone, and has a direct effect on the quality of togetherness,*' Pastor Ngendahayo (see also vignette 3). The headmaster of a secondary school said; '*neighbours, friends and colleagues visited each other after the war and genocide. Those meetings were always formal and distanced 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.*'

Civil servants refer people to socio groups, and group members help each other to make use of services offered by civil organizations. Another expression of the appreciation of sociotherapy is that it has been integrated in the poverty eradication programme in what was previously the Kisaro District in Byumba Province.

Vignette 3

'*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 trustworthy in such a short period of time! Some even wondered how people could easily become like members of ones family. (. . .) While asking myself these and many others questions, it came to my mind to think, 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 made up when there is consensus within the group. In the traditional gacaca the population had to participate half way, and the last words were reserved for the committee of the people with integrity.*'

(Source: Pastor Emmanuel Ngendahayo, coordinator Byumba Sociotherapy Programme, in *Community based sociotherapy in Byumba, Rwanda: Here we are*, a book (written mainly by programme staff and the 32 facilitators to be published in the summer of 2008.)

The donor

Already four months after the programme's implementation in April 2006, in reaction to the first positive responses to it, the Dutch donor agency Cordaid encouraged a national workshop in Rwanda's capital Kigali. Rwandans were invited to prepare for the workshop, which they gave the heading: '*The role of sociotherapy in community healing.*'

Representatives of some other organizations working in the field of trauma and healing, the Ministry of Health and Dr Simon Gasibirege, professor of psycho pedagogy in Rwanda, visited the Byumba programme before the workshop. Colleagues from different local NGOs, a few representatives from universities, the Ministry of Health, local authorities and organizations and delegates from

Burundi, Uganda, Congo and the Netherlands attended the workshop.

During the workshop, similarities and differences between various approaches in trauma healing, psychosocial support and reconciliation were discussed. The impact of community based sociotherapy in Byumba was evaluated, and delegates identified the method as valuable and potentially complementary to other interventions in the field represented during the workshop. In particular, the programme's capacity to provide high quality care to many, within a limited period of time was appreciated. The delegates adopted sociotherapy as a relevant method for addressing many post conflict social problems in the Great Lake region.

Based on the positive reception of the Byumba programme, Cordaid agreed to extend it until November of 2009. In addition, it was decided to allow the introduction of some differentiation in the programme by exploring if, and what kind of, body oriented therapy might be appropriate, to provide supervision for the facilitators, and to expand the programme to other areas in Byumba district. Cordaid also agreed to the development of a new sociotherapy programme, in Nyangezi, Congo. This programme started with training in September 2007, and its field implementation in January 2008. The development of a third sociotherapy programme is in progress, and will be implemented in Nyamata, Rwanda.

Challenges

Major success factors of the sociotherapy programme in Byumba have been the commitment of its staff and group facilitators, the active support of the Bishop of the EER Byumba at crucial moments, and the careful way the programme has been embedded within the local structures and adapted to the local culture. Despite its successes there are, however, from our point of view, also issues of concern. The concerns can be approached as shortcomings, but also as challenges and are discussed below.

There were frequent demands for an extension of the 15 group sessions, as well as requests from the facilitators for after-care of the beneficiaries. There were also wishes for differentiation and additional therapy methods expressed, a call for more help with income-generating activities, and the request to expand activities to other areas. Taken together, all of these may generate more than the programme can carry. It may seem a simple thing to add other therapeutic approaches (such as the often requested individual trauma-focused therapy) to sociotherapy, and to provide more forms of after-care (such as home visits) to beneficiaries. Facilitators themselves felt that they should do more to alleviate the individual suffering that confronted them. Even if this wish could be granted in terms of available infrastructure and financial support, the question is whether it is wise to do so at this stage of the programme. Can relatively inexperienced facilitators handle the differentiation in methods? From experience and the literature we know that people who suffer a lot, may compete with each other in terms of who suffers most. One way out of this for a facilitator could be to simply refer these people to a psychotherapist, however this may not always be the best response.

It may be wise to consider sociotherapy as a kind of primary health care intervention and, for the time being, leave it at that. Facilitators have to learn that they will never be able to meet all post genocide demands made on them, but that at the same time they are already doing a lot. They have to learn to deal with the limits of their capacity to help. Furthermore, a starting initiative needs time to mature. The group of 32 have now been

trained relatively well, and receive some local professional care. However, they are still beginners. This is even more the case with the second group of 75. Attention to training and emotional support of these facilitators is still far too limited. Also, the management skills of the staff and the Leading Team – including writing skills needed for the delivery of written reports – also need to develop further before a larger, more complicated, multidisciplinary programme can be steered properly. The answer to the question of who should take the responsibility and has the capacity to develop such a programme remains outside the scope of this article. We realize and agree that sociotherapy does have its limitations, in the sense that it cannot handle serious psychiatric problems, and may even provoke a request for individual trauma counselling or psychiatric treatment that (as yet) cannot be met. However, sociotherapy can provide the social hammock in which individual care could be embedded. The optimal situation would be a differentiated offer of care. Yet even if it cannot be done as it should be done, one should do what is possible within the given circumstances.

Quantitative extension of the programme to other regions requires support from existing organizations, management power, a plan and a well-equipped organization, able to embed a sociotherapy programme within the existing local structures. The programme in Nyangezi could already benefit from some of the lessons learned in Byumba. Because of different characteristics of the three areas – Byumba, Nyangezi and Nyamata – in terms of the history of the political violence in these areas and various area specific social and cultural aspects – we look forward to learning what the evaluation of all three programmes will teach us. Does sociotherapy work differently in these different contexts? If it does, what are the differences? Will it have the same impact? Do people in local contexts adapt the methods according to their specific needs, or is the approach that evolves in these different contexts more or less similar? These and related questions will occupy us in the time to come. The answers will be relevant for a further expansion of sociotherapy to areas in Rwanda and elsewhere in the Great Lake Region. Requests for this expansion have already been made.

Anticipating the expansion of sociotherapy to other areas in Rwanda, the wish for a local network and the development of a body of knowledge in the field of sociotherapy was expressed during the Kigali workshop mentioned above. With visits to each other's programmes, the sharing of oral and written information about the impact of the various kinds of community interventions, facilitators and beneficiaries of the different programmes could compare, analyze and interpret their experiences and contribute to their own body of knowledge. As far as sociotherapy is concerned, such a network could help to identify interest for sociotherapy in health, social, educational and theological institutes and their training colleges. In this way a network could help to make sociotherapy sustainable as the day will certainly come that donor support will end.

'*We wish our people at home had known this method before the conflicts erupted into violence*.' We cited this wish of refugees visiting trauma clinics in the Netherlands at the beginning of this article. These refugees were proved to be right. People in their home countries do indeed appreciate the sociotherapy method in the same way and with the same words.

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[1] In January 2006 the Rwandan government established new provinces, five in total. Byumba Province, one of the previous 12 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. That area is in this article still referred to as Byumba province. Also, recently the name of the Episcopal Church of Rwanda was changed to the Anglican Church of Rwanda. For the purposes of this article, we continue to use the name EER.

Annemiek Richters is professor of culture, health and illness at Leiden University Medical Centre (LUMC). email: j.m.richters@lumc.nl
Cora Dekker is sociotherapist in Equator treatment programme for traumatized refugees at the Academic Medical Centre in Amsterdam and Lecturer Social Work at University of Applied Science Leiden. email: cora.dekker@planet.nl, or dekker.co@hsleiden.nl
Willem F. Scholte is a psychiatrist working at the Academic Medical Centre in Amsterdam. He is the head of the Equator treatment programme for traumatized refugees, and the founder and chairman of Equator Foundation. email: wf.scholte@amc.uva.nl