Remembering and Re-Experiencing Trauma during Genocide Commemorations: The Effect of Supportive-Expressive Group Therapy in a Selected District Hospital in Rwanda

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Abstract

From the 7th to the 13th April, Rwanda commemorates annually the genocide perpetrated against Tutsi in 1994. This second week of April is annually associated in Rwanda with an increase in traumatic crises whereby many people participating in commemorating ceremonies present with various symptoms, including re-experiencing traumatic events of the 1994 genocide**.** This paper presents and discusses the results of a study on a supportive-expressive group therapy model implemented by mental health nurses in a rural setting for people who experience repeated traumatic crises in the context of the genocide commemoration in Rwanda. Even though the supportive-expressive group therapy was found ineffective for a series of variables studied (the number of crises presented in following commemorations, PTSD and depression symptoms), the results show that the intervention improved significantly the wellbeing of participants in terms of reduction of loneliness feelings and some negative emotions.

Key words: genocide, Rwanda, commemoration, traumatic crisis, supportive-expressive group therapy

Background

In April 1994, Rwanda suffered one of the worst genocides of the 20th century during which one million people (representing one-seventh of the country's population) were killed in 100 days. These people were not killed by an army from a foreign country but by fellow Rwandans, by neighbours and sometimes by close friends, who shared with victims the same culture, religious beliefs, language, and history and had lived on the same hills for many decades (Munyandamutsa, 2001, IRDP, 2006). The national service of Gacaca[1] Court put on trial 1,951,388 cases (representing two-seventh of the country's population) accused of participation in the genocide. These figures highlight the psychosocial trauma that has resulted in the Rwandan population. Currently, victims and ex-genocidaires liberated from prisons after the Gacaca trials have embarked upon a reconciliation process and are learning to live again together on the same hills. Therefore, it is not surprising that the prevalence of mental health disorders such as Post-Traumatic Stress Disorders (PTSD) and major depression have been reported at high rates during the past two decades. The latest national study reports that the PTSD prevalence is estimated to be 26.1% in the general population, while the prevalence rate for major depressive episodes is 22.7% (Munyandamutsa, Nkubamugisha, Gex- Fabry, & Eytan, 2012).

Remembering and re-experiencing trauma during commemorations

Evidence of genocide mental health consequences, despite being observed throughout the year, seem to be particularly acute during periods of genocide commemoration each year (Gishoma & Brackelaire, 2008). In Rwanda, the second week of April is annually associated with an increase in collective traumatic crises whereby many people participating in commemoration activities present with various symptoms, including re-experiencing traumatic events of the 1994 genocide. Some survivors are taken back to their past traumatic experiences, which are acted out in the present. They see militia armed with machetes, attacking them or cutting into pieces legs or arms of their families, or they see their house being burned as vividly as if was occurring again. They re-see and re-vision exactly what they saw, heard and felt in 1994.

These traumatic crises are quite contagious and can affect up to a hundred people at one commemoration site. For example, throughout the week of national mourning that ran from 7 to 13 April 2010, a total of 3193 people were reported to have developed these traumatic crises at different commemoration sites. The number of mental health crises during commemoration week has continued to be high in subsequent years: in 2011, 4363 people presented with a traumatic crisis; 4095 in 2012; 3702 in 2013 and 3471 in 2014 (Ministry of Health, 2010, 2011, 2012, 2013 and 2014).

Supportive-expressive group therapy for people experiencing crises at commemoration sites

The incidence of these mental health crises has prompted the Ministry of Health to establish special emergency interventions that allow effective management of the acute phase of crisis at commemoration sites. For a few people, going through a crisis might be a temporary experience without significant consequences in their daily lives. But for others, a crisis may be symptomatic of permanent and profound psychological trauma. However, previous interventions have focused primarily on the emergency period during the crisis.

1*Gacaca* was the traditional court used in Rwanda before colonisation, and to a lesser extent after independence, to resolve conflicts within the community. *Gacaca* literally mean "green grass" and refers to the physical green space where the court convened, typically in a central place of the village. *Gacaca* was conducted under the supervision of elders in the community or other individuals well-known for their integrity and wisdom. In the aftermath of the genocide this mechanism was reactivated to cope with the vast need for justice. Given the large numbers of accused, it would have taken hundreds of years to try everyone suspected of participation in the genocide killings because the judicial system was completely destroyed. The reactivated *Gacaca* courts consisted of weekly meetings of all the inhabitants of the village in order to speak out about what happened. Confessions, guilty plea and apologies were highly encouraged. The three objectives to be achieved by the renewed *Gacaca* were to: a) Reveal the truth about the Genocide; b) Speed up Genocide trials; and c) Contribute to national reconciliation. This whole process was managed over a period of 10 years by local elected judges among the population called *Inyangamugayo* (Republic of Rwanda, National Service of Gacaca court, 2012).

There has been inadequate follow up intervention for individuals who experience repetitive crises during commemoration, for those who do not regain their psychological health between crises, or for those who do not return for follow up at health services.

Based on the situation in Rwanda, and in order to complete the established emergency intervention, we implemented a supportive-expressive group therapy model for people who had experienced crises at commemoration sites. From a practical perspective, the supportive-expressive group was chosen because: a) it would be relatively easy to implement in a rural setting and had good cost-effectiveness potential; b) Remera - Rukoma mental health service, serving Kamonyi district had trained mental health nurses familiar with this approach; c) the supportive-expressive therapy technique was currently being used by some psychosocial institutions in Rwanda but had not been evaluated; and d) research demonstrated that the technique was well suited for survivors of traumatic events. In order to evaluate the supportive-expressive group therapy intervention, we designed a research study to evaluate the efficacy of this model implemented by mental health nurses in a rural setting.

Methods

Study design and data collection process

We used a quasi-experimental design with a between-subjects variable (supportive-expressive group vs. waiting list group that received the treatment after October 2011) and a within-subject variable (pre-test, mid-test, and post-test) to determine the effect of supportive-expressive group therapy on people experiencing crises during commemoration. Participants were recruited from individuals who experienced collective traumatic crises during commemoration ceremonies in April 2010 in the Kamonyi district, one of 30 administrative districts of the Republic of Rwanda. Specifically, the mental health nurse responsible for emergency intervention compiled a list of 85 people who presented with traumatic crises at major and small commemoration sites in the Kamonyi district. They were contacted several weeks after they recovered from the crisis and asked to participate in this research. From the list of 85 persons, 48 individuals met our inclusion criteria and agreed to participate in the study. Inclusion criteria were individuals who: a) had suffered from a traumatic crisis during the 2010 commemoration activities; b) had reported at least one other crisis in previous commemorations; c) resided in Kamonyi district or nearby; and d) were available for the duration of the study.

From the final sample (N = 48), 16 individuals were randomly assigned to the supportive-expressive group that started in January 2011 and the remaining participants (N=32) were assigned to the waiting list group. Neither the supportive-expressive group and nor the waiting-list group participants expected any intervention in the post-crisis stage since all participants were used to living with the symptoms and experiencing new crises during following commemorative ceremonies. Therefore the possibility of an intervention was not mentioned to the waiting list participants. This group was simply asked to participate in research about collective traumatic crisis during commemorations and to complete a questionnaires on three occasions (ie, January, April and October). These questionnaires were completed during the same week as those in the supportive-expressive group. After October 2011, the waiting list participants were offered counseling by the same facilitators from mental health services at Remera-Rukoma hospital. The dropout rate during the last data collection phase was 6.25%.

The completion of the questionnaires by both groups and the supportive-expressive group sessions were held in rooms provided by the Remera-Rukoma hospital. Depending on where the participant lived, he/she received between 1,600 and 4,000 RWFs (2 and 5 Euros) as compensation for their transport each time they travelled to participate in supportive-expressive groups or to complete questionnaires.The Ethical approval for this study was obtained from the mental health division, Ministry of Health and from Remera - Rukoma Hospital on 20/11/2009.

Intervention

The intervention consisted of a 10 month programme during which various aspects of mutual support, expression of emotion and thoughts related to the crisis and the genocide, and the management and control of symptoms were discussed. The 16 members of the intervention group met monthly from January to October 2011, with each session lasting 120 to 150 minutes. The group sessions were facilitated by two psychiatric nurses working for the

mental health unit of Remera-Rukoma hospital and a clinical psychologist from Kigali Health Institute. Participants were offered a space where they could share what was haunting them and were assured that they would be listened to. They were allowed to talk about themselves and to put into words what they lived and expressed during a crisis. During the intervention, the expression of thoughts and feelings related to the lived experience during the commemoration period were encouraged. The researchers also tried to search for meaning in the participants' experience, explore symptom control, identify strategies to prevent relapses at future commemorations and deal with other additional concerns expressed by participants. At the end of each session the participants were guided through relaxation exercises. Given that participants were primarily evangelical Christians, similar to the majority of the population in the Remera-Rukoma hospital catchment area, they proposed ending some sessions with religious songs and short periods of dancing. We accepted these participants' suggestions. The attendance rate for the supportive-expressive groups was 96.6%.

Measures

We were able to use the Kinyarwanda versions of tools that had been used in different studies conducted with Rwandan samples, except for the impact of event-scale- Revised (IES-R). Several tools were used to assess the expected outcomes from the intervention and the mental health status of participants before, during, and after the intervention:

* **Socio-demographic profile:** A structured questionnaire was developed to collect information on the socio-demographic profile, including age, sex, marital status, socioeconomic status, and employment of participants. We also collected information on traumatic events experienced by the person during the genocide (being hunted by killers, witnessing violence/ torture/mass murder, and being tortured/ wounded), grief and loss of family members, and crises during commemoration activities (number of crises, dates, relapses).
* **The Izard's Differential Emotions Scale-DES**: We used the abbreviated version of Izard's Differential Emotions Scale-DES (Izard, 1977) to evaluate the intensity of the emotions felt by people who had experienced collective traumatic crisis during the genocide commemoration period in Rwanda. This scale was administered three times during the intervention (January, May, and October). The Izard's Differential Emotions Scale-DES has been shown to be valid and reliable in a wide range of settings (Akande, 2002) and has been translated to Kinyarwanda by Kanyangara and colleagues (Kanyangara, 2008; Kanyangara, Rimé, Philippot, & Yzerbyt, 2007). The internal consistency of the Kinyarwanda version used in this study proved to be acceptable with a Cronbach's alpha =.755 at the pre-intervention and =.667 at the post-intervention phase.
* **The University of California, Los Angeles Loneliness Scale (The UCLA Loneliness Scale):** The 10-item scale (Russell et al., 1980) assesses people's perception of their feeling of loneliness. The UCLA Loneliness Scale is widely used (Cacioppo & Hawkley, 2009; McWhirter, 1990) and the validity of the scale has been reported as highly correlated with other loneliness measures such as the NYU Loneliness Scale and the Differential Loneliness scale (Russel, 1996). We used the Kinyarwanda version of the UCLA Loneliness Scale (Sezibera, 2008). In the current study, the internal consistency of the Kinyarwanda version was acceptable with a Cronbach's alpha =.667 at the pre- intervention and =.704 at the post-intervention phase.
* **The Center for Epidemiologic Studies Short Depression (CES-D) Scale:** We used the CES-D 10 scale (Anderson & Malmgren, 1994) composed of 10 items linked with the main symptoms of depression. The reliability and validity of the CES-D scale have been confirmed in a wide range of international settings and with different populations including African American, Asian American, French, Greek, Hispanic, Japanese, and Yugoslavian (Naughton & Wiklund, 1993). The scale has also been used with samples of adolescents and adults in Rwanda (Boris et al., 2008; Cohen et al., 2009). The internal consistency of the Kinyarwanda version was α = .584 at the pre-intervention phase and α = .660 at the post-intervention phase.
* **The impact of event-scale-Revised (IES-R):** The IES-R is a self-report scale developed by

Weiss and Marmar (1997) to measure PTSD symptoms. It is made up of 22 items and grouped into three subscales. This instrument is based on the impact of event scale (IES) developed by Horowitz, Wilner, and Alverez (1979) and has been used several times in research with victims of traumatic events in sub-Saharan African countries (Derluyn, Broekaert, Schuyten, & De Temmerman, 2004; Mels, Derluyn, Broekaert, & Rosseel, 2009). The IES-R has shown to be valid and reliable in a wide range of settings (Brunet, St-Hilaire, Jehel, King, 2003; Christianson & Marren, 2013). It was the only tool we used that had not been previously translated into Kinyarwanda. To the best of our knowledge, this tool has not been used previously with a Rwandan sample. The tool was translated into Kinyarwanda by two Rwandan clinical psychologists who worked separately; two other Rwandan clinical psychologists carried out a back translation (Choi, Kushner, Mill & Lai, 2012) of the Kinarwanda IES-R tool. A meeting between independent translators and the first author confirmed the accuracy of the Kinyarwanda version of the tool. The internal consistency of the Kinyarwanda version we used was found to be acceptable: pre-test α = .899 and post-test α = .897.

* **Wagnild and Young's resilience scale:** We measured resilience using the Resilience scale (RS) developed by Wagnild and Young (1993). Ahern and colleagues (2006) argued that the RS scale was the best instrument to measure resilience in the adolescent and adult population, compared to six other instruments they evaluated. This instrument was translated to Kinyarwanda by Ionescu et al. (2011). The Cronbach's alpha of the Kinyarwanda version used in this study was α =.919 (pre-intervention) and α =.916 (post intervention).

Results

Equivalence of supportive-expressive group and waiting-list group

With reference to socio-demographic profile, preliminary analyses revealed that the two groups did not differ significantly except for the respondents' socio-economic status (c2 (1, n=45) =6.894, p=.018), all other p > .09. Preliminary analyses also indicated that individuals who had experienced a traumatic crisis during the genocide commemoration period in Rwanda in both the intervention group and waiting list groups had lost a large number of close family members (i.e. parents, siblings, children, and/or spouse) during the genocide. The mean number of family members lost was 7 persons for each person in both the supportive-expressive group (M=7.33, SD = 3.519) and the waiting list group (M=7.43, SD =2.54). Participants had also been exposed to a large number of traumatic events during and after the genocide. The mean number of collective traumatic crises experienced per participant was found to be 13 (SD=7.20) in the supportive-expressive group and 14.90 (SD=5.92) in the waiting-list group.

The intervention effect

Reducing the number of crises

It was expected that supportive-expressive groups would effectively prevent crises or at least reduce the number of relapses during subsequent commemorations. We observed that at time 3 in the intervention (October 2011) 80% of participants in the supportive-expressive group had experienced at least one relapse (range 1 - 7) when participating in the 2011 genocide commemoration activities; 76.66% experienced at least one relapse (range 1 - 5) in the waiting list group, (χ2(1, n = 45) = 0.64, p = .80). A t-test comparing the number of crises between the two groups confirmed that the mean number of crises experienced by the therapy group, M = 1.87, SD = 1.76, was no different than the waiting list group (M = 2.03, SD = 1.47, t (43) = 0.34, p = .740).

Effect of the supportive-expressive intervention on the emotional state, PTSD, depression symptoms, loneliness and resilience scores

Analyses of Variance (ANOVAs) with treatment (supportive-expressive group vs. waiting list group) as the between-participants factor and time (before intervention T1, during intervention T2, after intervention T3) as the within-participant factor were computed on the DES total score and the emotion measures. Cases with missing data were omitted during analysis. Results are displayed in table 1 and 2.

Table 1. Mean Scores, Standard Deviations and ANOVA Results

Emotion	Intervention group M (SD)			Waiting list group M (SD)			ANOVA Treatment	Time		T × T	
	T1	T2	T3	T1	T2	T3	*F (1, 43)* η_p^2	*df*	*F* η_p^2	*df*	*F* η_p^2
Sadness	4.73 *(0.96)*	5.40 (0.63)	3.47 (1.35)	5.07 *(1.04)*	5.87 *(0.43)*	4.83 *(1.05)*	9.94** *.18*	*(1.84, 79.16)*	41.03*** *.48*	*(1.84, 79.16)*	5.89** *.12*
Anger	3.00 *(1.30)*	3.93 *(1.38)*	3.47 *(1.24)*	3.07 *(1.85)*	3.97 *(2.15)*	3.23 *(2.06)*	0.00 .00	*(1.67, 71.97)*	14.80*** *.25*	(1.67, 71.97)	0.46 *.01*
Fear	4.36 *(1.00)*	5.79 *(0.57)*	4.43 *(0.75)*	4.63 *(1.21)*	5.77 *(0.62)*	4.87 *(1.25)*	0.82 *.01*	*(2, 84)*	33.86*** *.44*	*(2, 86)*	0.92 *.02*
Disgust	4.50 *(0.76)*	5.36 *(1.15)*	3.14 *(1.02)*	4.87 *(1.52)*	5.63 *(0.71)*	4.40 *(1.75)*	3.15 *.07*	*(2, 84)*	41.72*** *.49*	*(2, 86)*	4.12* *.08*
Anxiety	4.27 (1.22)	5.73 (0.59)	4.53 (0.99)	4.73 (1.38)	5.63 (0.66)	4.83 (1.64)	0.45 *.01*	*(2, 86)*	30.49*** *.41*	*(2, 86)*	1.59 *.03*
Shame	1.60 (2.13)	0.60 (1.24)	2.73 (2.05)	2.47 (2.64)	1.47 (1.90)	2.33 (2.51)	0.48 *.01*	*(2, 86)*	18.22*** *.29*	*(2, 86)*	4.17* *.08*

*p < .05, **p < .01, ***p < .001

Table 2. UCLA-R, IES-R, CES-D, RS Mean Scores, Standard Deviations and ANOVA Results

	Intervention group M (SD)			Waiting list group M (SD)			ANOVA Treatment	Time		T × T	
	T1	T2	T3	T1	T2	T3	*F(1,42)* η_p^2	*df*	*F* η_p^2	*df*	*F* η_p^2
UCLA-R	34.28 (2.99)	32.71 (3.53)	26.28 (2.33)	33.33 (4.04)	32.56 (4.33)	33.76 (3.80)	3.56 .07	(2, 84)	45.45*** .52	(2, 84)	65.59*** .61
CES-D	19.15 (3.95)	20.46 (4.01)	17.07 (3.89)	19.40 (3.82)	20.96 (3.10)	18.86 (3.61)	0.69 .01	(2, 76)	9.25*** .19	(2, 76)	1.03 .02
IES-R	61.61 (12.33)	72.46 (9.60)	61.61 (12.65)	58.68 (15.18)	71.82 (9.08)	58.00 (14.70)	0.36 .00	(1.10, 44.31)	47.21*** .54	(1.10, 44.31)	0.58 .01
RS	117.50 (16.67)	116.14 (16.16)	119.21 (14.67)	114.11 (28.19)	114.25 (26.72)	116.39 (28.66)	0.11 .00	(2, 80)	3.31* .07	(2, 80)	0.25 .00

*p < .05, **p < .01, ***p < .001

As reported in Table 1, a significant treatment × time interaction effect was found on the measures of sadness (F (1.84, 79.16) = 5.89, p=.004, η_p^2 =.12), disgust (F(2, 86)=4.12, p=.02, η_p^2 =.08) and shame (F(2, 86)=4.17, p=.01, η_p^2 =.08). Interaction contrast analysis (with Bonferroni adjustment) revealed that differences that were not significant at Time 1 and 2 were found to be significant at Time 3 for disgust (t(41) = 3.20, p = .003), and for sadness (t(43) = 3.72, p =.001). Thus, the supportive-expressive group participants experienced less sadness and disgust after 10 months of treatment compared to those on the waiting list.

Similarly, a significant treatment × time interaction effect for loneliness (F (2, 84) = 65.59, = .00, η_p^2 = .61), was found with the two conditions similar at Time 1 (t (42) = 1.01, p = .317) and Time 2 (t (42) = 0.11, p = .912) but a significant difference was observed at Time 3 (t (42) = 6.95, p < .001). The supportive-expressive group participants experienced less loneliness after 10 months of treatment compared to those on the waiting list. Figure 1 illustrates this outcome pattern.

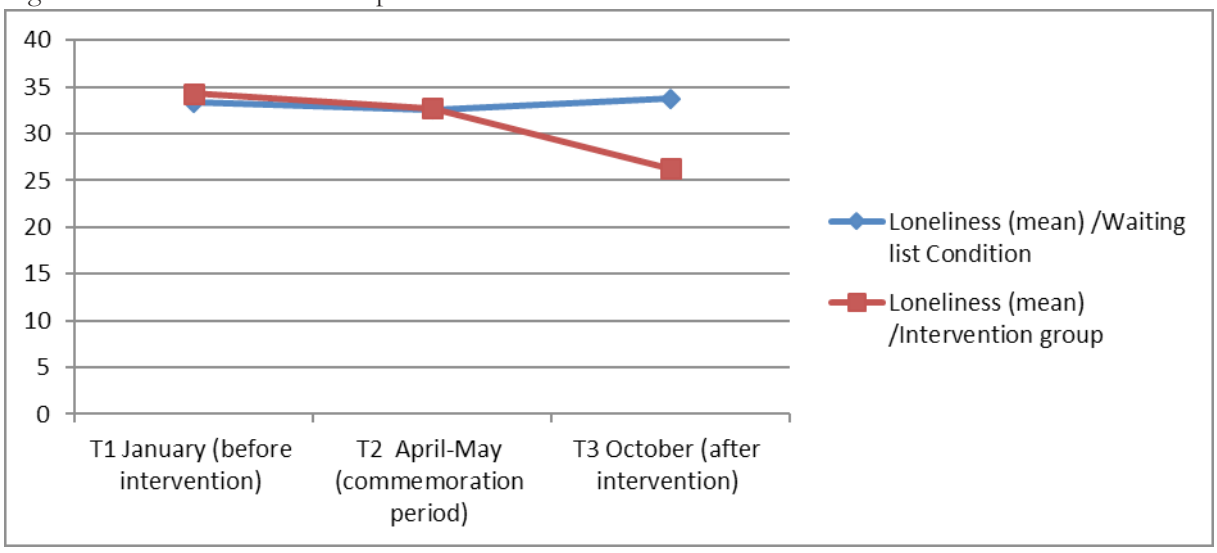

Figure 1. The comparison of the loneliness feeling between waiting list and intervention groups across the course of the study.

Discussion and conclusion

There were several limitations in the design and implementation of the study. First, the intervention did not directly target the traumatic nucleus as is done in some group and individual therapy that systematically targets PTSD. Instead, the intervention targeted the overall wellbeing of participants. The second limitation relates to the small number of participants and the participant selection process. The researchers and the mental health nurses involved in the care of the participants at commemoration sites were the same ones that delivered the intervention and co-facilitated the groups. This was a deliberate choice to ensure that there was continuity in the intervention started at the commemoration sites when an individual experienced a traumatic crisis. Therefore, due to the specific context of this study, there was no guarantee of blindness of the therapist to the treatment condition. Finally there were some socioeconomic differences between the two groups.

Further studies are needed with a larger sample size and using multiple groups in order to control the effect of non independence of observations. In addition research should be designed and tested using an intervention that directly targets core PTSD and depression symptoms.

Prior to beginning the study, participants from the intervention and waiting list groups did not differ significantly on the outcomes measured. However, after 10 months of intervention, the results show that participants in the intervention group improved significantly compared to participants in the comparison group in terms of sadness, disgust, and loneliness. This study does not, however, demonstrate a significant effect for several other variables studied (relapses, depression, and PTSD symptoms, resilience score, and intensity of anger, fear, anxiety, and shame). This suggests that the proposed intervention has a significant effect on *certain aspects of psychosocial wellbeing* of people with traumatic crises during genocide commemorations but might not be able to fully resolve all the issues associated with traumatic crises and their underlying psychopathology.

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