Counsellors in session with a client who survived the Al-Shabaab bombings in Kampala, Uganda on July 11th 2010. 80 people died. (Reference: http://kjohnan.instablogs.com/entry/shocking-pictures-of-kampala-bomb-blasts-711/)

Cover story: Lifeless bodies lying scattered after the Al-Shabaab terrorist bombing in Kampala, Uganda on July 11th 2010. 80 people died. (Reference: http://kjohnan.instablogs.com/entry/shocking-pictures-of-kampala-bomb-blasts-711/)

Counsellors in session with a client who survived the Al-Shabaab bombings in Kampala, Uganda on July 11th 2010. (Ref: Basic Needs UK in Uganda Report, July 2010)
ABOUT THE AFRICAN JOURNAL OF TRAUMATIC STRESS

The African Journal of Traumatic Stress (AJTS) was established after the long realization of the need for all workers caring for traumatized people in Africa, to communicate to each other, to share experiences, knowledge, skills and to support each other. It was realized that there was a need to document and communicate all this knowledge to a wider audience beyond the African continent for the world to know, appreciate and help the traumatized peoples of Africa in the context of the now globalized increase of torture and organized violence as well as other man-made and natural disasters.

The primary objective of the AJTS is to provide a forum for discussion and presentation of papers to enhance the care and rehabilitation of the traumatized people’s of Africa and beyond and ultimately to contribute to prevention efforts to eradicate this evil of torture and organized violence as well from Africa and the world at large.

The AJTS will publish original papers from wide and far-reaching multi-disciplinary backgrounds, including research papers, field experiences, new innovations in care, reports, commentaries, book reviews and even personal stories. Evidence-based papers will be of paramount importance. Short communications, newsworthy reports, review papers, cross cutting issues as well as picture-stories will all be welcome. The AJTS does not espouse any particular ideology/philosophical view but believes in the universal respect to human rights for all, in good participatory democratic governance and in the empowerment and protection of vulnerable groups and all peoples from exploitation and oppression and advocates for an end to warfare and all its industry; and for peace, freedom and justice for all the peoples of the world irrespective of race, colour, creed, ethnicity, religion, gender, age or political persuasion.

All opinions and articles published in the AJTS will reflect views of the authors and not necessarily views of the Journal. Prejudicial and hate literature will not be allowed. The authors will have to accept the terms and conditions as outlined in the “Guide to Authors” page of the Journal. Papers submitted to the AJTS will not have been submitted for publication elsewhere. After acceptance for publication, the author(s) will transfer copyrights of the accepted articles to the AJTS unless if accepted by the copyright holders.

The AJTS is copyrighted. All those wishing to use illustrations from the AJTS in other publications will first obtain permission from the publisher and will acknowledge the particular issue of the AJTS as the source of the material. Announcements and other informations may be allowed in the Journal but must conform to the terms and conditions so set.

The AJTS is published by Makerere University College of Health Sciences in collaboration with the Peter C. Alderman Foundation (PCAF). There will be two issues per year. For more information please contact the AJTS website www.petercaldermanfoundation.org
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Editorial</td>
<td>54</td>
</tr>
<tr>
<td>Psychotrauma, Healing and Reconciliation in Rwanda- The contribution of Community-based Sociotherapy</td>
<td>55</td>
</tr>
<tr>
<td>Annemiek Richter, Théoneste Rutayisire, Theophile Sewimfura, Emmanuel Ngendahayo</td>
<td></td>
</tr>
<tr>
<td>Traumatic Legacy: An analysis of Tanzania’s Refugee Mental Health challenge</td>
<td>64</td>
</tr>
<tr>
<td>R. Ronnenberg, N. Emmanuel, M. Hogan, M.B. Sebit, G.P. Kilonzo</td>
<td></td>
</tr>
<tr>
<td>Children’s Management of Complaints Symptomatic of Psychological distress: A critical analysis of the different approaches in Northern Uganda</td>
<td>70</td>
</tr>
<tr>
<td>Grace Akello, Annemiek Richters &amp; Emilio Ovuga</td>
<td></td>
</tr>
<tr>
<td>Culture and Traditional Healing in conflict/post-conflict societies</td>
<td>80</td>
</tr>
<tr>
<td>Seggane Musisi, Elialilia S. Okello and Catherine Abbo.</td>
<td></td>
</tr>
<tr>
<td>Outcomes of the Psychosocial response to persons affected by the Kampala bombings of July 11th, 2010</td>
<td>86</td>
</tr>
<tr>
<td>Christina Ntulo, Margaret Mugherera and Sheila Ndyanabangi</td>
<td></td>
</tr>
<tr>
<td>Mental health disorders among ‘arrived’ refugees in Tanzania</td>
<td>94</td>
</tr>
<tr>
<td>M.B. Sebit, G.P. Kilonzo</td>
<td></td>
</tr>
<tr>
<td>Prevalence and correlates of Psychological distress as seen in post-conflict Liberia</td>
<td>96</td>
</tr>
<tr>
<td>Eugene Kinyanda, Mwaka Nakiboneka, Ojiambo Ochieng, Were-Oguttu, Gayflor, Liebling-Kalifani, Howard Diawara</td>
<td></td>
</tr>
<tr>
<td>The need for mental healthcare in the context of conflict in the Niger-Delta of Nigeria: an analysis of the problem</td>
<td>103</td>
</tr>
<tr>
<td>Olugbile O.B, Coker A.O</td>
<td></td>
</tr>
</tbody>
</table>
ABOUT THE PETER C. ALDERMAN FOUNDATION

The Peter C. Alderman Foundation is a non-profit organization established by Dr. Steven and Mrs. Elizabeth Alderman to help traumatized survivors the world over to heal from the mental health effects of trauma.

The Foundation is named after Peter C. Alderman, the second son of the Aldermans who was killed in the September 11, 2001 terrorist attacks on the World Trade Centre, New York City, USA. He was at the tender age of 25. In memory of their son, the Aldermans, together with friends and relatives, decided to do something positive about their grief, hence the Foundation.

The Foundation’s mission statement is “To heal the emotional wounds of victims of terrorism and mass violence by training doctors and establishing trauma treatment centres in post-conflict countries around the globe.”

As part of its mission, the Foundation works to alleviate the suffering of war survivors in communities affected by conflict. The Foundation aims to provide holistic mental health care including (but not limited to) physicians, psychiatric clinical officers, psychiatric nurses, counselors and psychiatric social workers in these areas and to equip them with the tools to treat mental disorder using western medical therapies in combination with local healing traditions.

To fulfill this mission; the Foundation provides services in the areas of:
1. Mental health care to war affected persons through supporting “Trauma Treatment Clinics.”
2. Psychosocial support to vulnerable peoples like formerly abducted children, former child soldiers, victims of rape, war widows, single mothers and HIV/AIDS patients in the war affected communities.
3. Training health workers in the war affected areas in the management of the mental health effects of war.
4. Awareness raising, sensitization, mobilization and holding training workshops on management of trauma.
5. Research in the mental health effects of war trauma on the population.

To achieve these objectives the Foundation works with and within existing Ministry of Health structures of the host country. In Africa, the Foundation currently supports work in Uganda (three trauma clinics and soon to open a fourth clinic) and Rwanda (one clinic) and is soon to open up a service in Liberia and Kenya.
Mass trauma has bedeviled Africa for more than 500 years. From the more than 400 years of slave raids and the slave trade, came the violent exploration, division and colonization of the continent. This was accompanied with the missionary zeal to “civilize” the continent by way of forced evangelization through Christianity and Islam and the consequent religious wars in many parts of Africa as these two fought for the African souls. These were followed by the various armed struggles for independence throughout the continent. But, alas, post-independent Africa continues to be besieged by endless warfare and violent conflicts within and between countries. Barely one week after the last PCAF conference in Nairobi in July 2010, Uganda was rocked by terrorist bombs as people sat watching the final football matches of the World Cup. Elsewhere in Africa marauding armies, warlords, dictators, armed militias etc roamed the continent. Violent ethnic, political and religious conflicts continue as well as the struggle to control the continent’s resources (oil, minerals, timber etc). Most are fueled by global forces beyond the continent’s ability to stop. Recently a new twist of mass uprisings has happened in North Africa with its toll on the Africa masses. This new phenomenon, with its domino effect, is threatening to engulf the rest of Africa as a bushfire. In all these conflicts, millions of Africans have lost their lives, been displaced, exiled and physically, psychologically and socially tortured with hardly any efforts to ameliorate these deleterious psycho-traumatic sequels to the African masses.

In this second issue of the African Journal of Traumatic Stress, AJTS, we continue to exchange ideas, stories and knowledge regarding how to care for the victims of the now endemic problem of mass violence which continues to bedevil this continent. This issue presents hands-on experiences of various therapists in Africa, in their endeavors at healing the often invisible wounds of mass violence on this continent. This issue discusses the concept of using lessons from “traditional wisdom” and community-based approaches integrated with modern methods in dealing with the traumatized survivors of today’s African violence.
Introduction
Rwanda has suffered from a long history of political violence, regional and ethnic discrimination, oppression and poverty. Twenty years ago this history culminated into civil war (1990-1994) followed by hundred days of genocide (April-July 1994) and continuing violence in its immediate aftermath (Newbury 1988; Prunier 2009). The genocidal violence targeted primarily the Tutsi (composing 10-15 percent of the population of Rwanda), but also some Hutu political opponents and civil society activists.

A history of ethnic killings preceded this genocide. Massacres of Tutsis began in 1959 with the transfer of power in favour of the Hutu elite through political violence. This was followed by repression and various episodes of massacres, which resulted in many Tutsi choosing to go into exile. On the first of October 1990, the Rwandan Patriotic Front (RPF) - an anti-Rwandan-government armed movement, initially composed largely of Tutsi who had lived in exile for a generation - invaded Rwanda from the north-east. It was a power struggle that began in the context of the ensuing civil war.

When the plane of President Habyarimana was shot down on the sixth of April 1994, it triggered the genocide. Eventually, the RPF gained a victory over the previous government and its army, ended the genocide, and established a new RPF-led regime.

Annemiek Richters*, Théoneste Rutayisire†, Theophile Sewimfura‡, Emmanuel Ngendahayo§

1. Department of Public Health and Primary Care, Leiden University Medical Center, PO Box 9600, 2300 RC Leiden, The Netherlands
2. Nyamata and Byumba Sociotherapy Programs. P.O. Box 4022, Kigali, Rwanda
3. National Director Mercy Ministries International Office Rwanda. P.O. Box 5090, Kigali, Rwanda
4. Byumba community-based sociotherapy program, P.O. Box 17, Byumba, Rwanda

Abstract

Introduction: In post-genocide Rwanda, many different kind of interventions have been implemented on different levels of society focusing on the healing of psychological problems and reconciliation between victims and perpetrators of the previous political violence. This article presents the practice of community-based sociotherapy and its impact in terms of healing and reconciliation as well as its specificity compared to other interventions.

Methodology: A variety of qualitative research methods were used with an emphasis on the most significant-change-stories method.

Results: Sociotherapy was introduced in Rwanda in 2005. Sociotherapy groups of 10-12 people living in the same neighborhood meet once a week during 2-3 hours for a period of 15 weeks. The most significant problems people suffer from due to the political violence is the destruction of social relations. It is in the phase of care that is usually reached during the 4th or 5th session that a change in people’s behavior and interaction with others, including former enemies, takes place. This change results in a rerouting of their personal, family and community life which is experienced as a release of problems previously buried in people’s hearts. While many of the interventions in Rwanda which are specifically aimed at reconciliation result at most, in ‘thin’ reconciliation, sociotherapy resulted, in many cases, in ‘thick’ reconciliation.

Conclusion: Justice and care should complement each other when the aim is healing from the wounds of a violent past and reconciliation along ethnic lines.

Key words: Care, community-based, healing, reconciliation, sociotherapy, trauma, Rwanda

PSYCHOTRAUMA, HEALING AND RECONCILIATION IN RWANDA - THE CONTRIBUTION OF COMMUNITY-BASED SOCIOTHERAPY

Correspondence:
Annemiek Richters
Department of Public Health and Primary Care
Leiden University Medical Center
P.O. Box 9600, 2300 RC Leiden, The Netherlands
The most recent official number of people who were brutally murdered during the 1994 genocide is one million and fifty thousand (1,050,000). Over two million people were forced into exile in the neighbouring countries, and hundreds of thousands of people were displaced inside the country. Rwanda was left with thousands of people who survived sexual violence and mutilation, widows, orphans, and the detention of around one hundred and thirty thousand (130,000) individuals suspected of participation in the violence (Tiemessen 2004). The infrastructure was destroyed and social links were severed. Killings and abuse by all parties involved in the conflict continued after the genocide, with the motive for Tutsis often being revenge. The collective result of all these horrendous deeds over the years could only be mistrust and hatred in all human ties that make life meaningful, affecting all groups and leaving a society in disarray.

Despite many efforts invested in healing an utterly broken society, the country today is still marked by feelings of mistrust, desperation, uncertainty and social isolation among its population. These problems are to a large extent a direct consequence of the tragedies Rwanda went through, but they can also be a spin-off or side-effect of interventions aimed at unity and reconciliation. An example of such intervention is the community-based justice system (gacaca), which we will discuss below. Since the end of 1994, the new Rwandan government has made the promotion of national reconciliation central to its political program. This vast enterprise has included both judicial responses and non-judicial strategies. With the help of the international community, three judicial responses were implemented: the International Criminal Tribunal for Rwanda (ICTR) in Arusha, Tanzania national-level domestic genocide trials within the regular court system and local-level gacaca courts. The latter are a modernized form of traditional gacaca, a community-based conflict resolution institution. The pilot phase of gacaca began in June 2002 and gacaca was launched nationwide two years later.

The non-judicial strategies include the creation of a Government of National Unity and a National Commission for Unity and Reconciliation, the public condemnation of the genocide, the promotion of a democratic culture, the creation of a socially responsible citizenry, the building and good maintenance of genocide memorial sites, the promotion of various national commemoration events, new national symbols to shape the collective memory of Rwandan history, an annual national Day of Heroes highlighting individuals who have fought ethnic division, the suppression of the mention of ethnicity on identity cards, school programs, reeducation or solidarity camps (ingando), and government development programs such as the one-cow-per-poor-family (girinka) program. The latter is one of the Economic Development and Poverty Reduction Strategies (EDPRS) which are believed to have an impact on the reconciliation process. In addition, the government stimulates trauma healing programs. It has lately been acknowledged that also perpetrators may suffer from psychological problems for which they need help. While the judicial response and the memorialisation strategies are both meant to contribute to African Journal of Traumatic Stress Vol 1 No. 2 Dec 2010 /57 reconciliation, they also have the potential to generate or increase health problems which may thwart reconciliation.

One of the possible definitions of reconciliation is: “the process by which parties that have experienced an oppressive relationship or a destructive conflict with each other move to attain or to restore a relationship that they believe to be minimally acceptable” (Kriesberg 2001:60). In Rwanda this kind of reconciliation would be referred to as kubana, which stands for living together as a matter of necessity. It is a superficial or ‘thin’ kind of reconciliation and should be distinguished from ubwiyunge, ‘thick’ reconciliation, which is a matter of the heart and a state of feeling in social relations (Ingelaere 2009:514). It involves speaking truthfully and honestly about what happened and starting new relationships based on trust and respect.

Like in other post-conflict reconciliation processes around the world, truth telling has come to play a pivotal role in reconciliation in Rwanda (Brounéus 2010). This is clearly expressed in the policies regarding gacaca. The objectives of gacaca were to relieve the regular courts by speeding up the genocide trials, bring justice and (where necessary) punishment to lower- and middle-echelon criminals, reveal the truth about events during the genocide, eradicate undeserved impunity, and stimulate healing and reconciliation (National Service of Gacaca Jurisdictions 2004). The nation-wide implementation of gacaca was preceded by a massive campaign to sensitize the population about gacaca and especially about the benefits of telling the truth. On billboards promoting gacaca jurisdiction across the country, the vision that truth leads to healing was expressed in the text printed below a representation of the terrible suffering caused by the genocide: “The truth heals - Tell what we have seen, admit what has been done and move forward to healing” (Ukuri kurakiza - Tuvuge ibyo twabonye, twemere ibyo twakoze bizadukiza).
The idea is that healing from individual psychological wounds will lead to reconciliation. Healing and reconciliation is supposed to be advanced through uncovering past wrongs, introducing closure, and moving on to a consolidated peace (Buckley-Zistel 2005:113).

Studies done on the effect of gacaca agree that, of all the gacaca objectives, healing and reconciliation is the least often met (e.g. Buckley-Zistel 2005; Brounéus 2010; Ingelaere 2009; Tiemessen 2004). One of the interfering factors is found to be psychological ill health.

Two different surveys conducted in Rwanda on this issue give us some insight in the relation between psychotrauma, justice and reconciliation. The survey conducted by Pham et al. (2004) found that there was a high exposure of trauma among its 2074 respondents and that 24.8% met criteria for PTSD. Respondents who had experienced exposure to multiple trauma events or met the criteria for PTSD were less likely to support the gacaca trials and were less open to reconciliation. The survey conducted by Brounéus (2010), in which 1200 Rwandans participated, demonstrated that gacaca witnesses - whether genocide survivors, neighbours or inyangamugayo (lay judges) - suffer from higher levels of depression and PTSD than non-witnesses. This finding suggests that participation in gacaca for many of its participants is more distressing than healing. Brounéus (2010:430) concludes from her findings that for psychological healing, methods other than truth-telling mechanisms should be sought.

In this article we will explore the contribution community-based sociotherapy can make to both healing and reconciliation in post genocide Rwanda and can as such complement governmental activities aimed at ‘unity and reconciliation’ as well as reconciliation efforts made by churches, non-governmental and international organizations and local civic initiatives. Before we present the methods of the qualitative field study on which this article is based, we provide some basic information about sociotherapy as it is implemented in Rwanda.

COMMUNITY-BASED SOCIOThERAPY

Sociotherapy was introduced in Rwanda in 2005 in the region of Byumba in the north of the country with three objectives: fostering feelings of dignity, safety and trust for all survivors of war and genocide; reducing mental and social distress; and getting rid of disturbed and delayed development. In 2008 a second program with the same objectives started in the region of Nyamata (Bugesera district) in the south-east. The first program was implemented by the Byumba Diocese of the Episcopal (recently renamed as Anglican) Church of Rwanda (EER; Eglise Episcopale au Rwanda) and the second by the NGO Faith Victory Association. Both programs adapted the hospital-based sociotherapy as practiced in the Netherlands for traumatized refugees to the needs of traumatized individuals and communities in Rwanda. The programs continued to be adapted by the local staff and sociotherapy group facilitators as they evolved. In the process it became clear that the needs to be addressed proved to be somewhat different in Byumba and Nyamata (see below).

A major initial adaptation was the replacement of a clinic-based approach by a community-based approach. This resulted in a set-up of weekly meetings of sociotherapy groups of ten to twelve people (living in the same area) per group, for approximately three hours over a period of fifteen weeks. These meetings are held in a safe place located in participants’ direct living environment. The location can be a school, a church, an office, a private sitting room, a place under a tree, or the grass in the open air. Facilitators guide the groups through the phases of safety, trust, care, respect, rules, and memories. Throughout the journey the following six principles are applied: interest, equality, democracy, participation, responsibility, and learning-by-doing by using current situations (see for more information Richters et al. 2008; Richters 2010). It is the dynamic complexity of principles and phases as a whole that makes sociotherapy work the way it does. “Both, phases and principles, encourage everyone to take care of each other in order to reduce or resolve each other’s problems” (sociotherapist).

Another adaptation was the addition of the principle of inter-est to the 5 principles applied in the Netherlands. The expatriate trainer Cora Dekker derived the concept of inter-est from the work of the philosopher Hannah Arendt (1958). Inter-est refers to the space between us as human beings or the web of human relationships; a web that was severely damaged by the political violence people in Rwanda experienced. Participants in sociotherapy express frequently that they have experienced this damage as a loss of their humanity. “I had gone out of society and become like an animal”, Veronique, a young educated woman whose husband was imprisoned, told us about her life before she had joined sociotherapy. For Alphonse, an exprisoner, the biggest problem after his release from prison is, next to poverty, “where are you going with your neighbors; in other words, relationships: how do you live with those you offended, how do you live with those who offended you, and how do you live with your family”. Veronique, Alphonse and many other African Journal of Traumatic Stress Vo 1 No. 2 Dec 2010 /59 sociotherapy participants confirmed to us that the most devastating effects of violence “are not on individuals per se but on the fields of interrelationships that constitute their
visits, documentation of sociotherapy group meetings and income generating activities that were part of sociotherapy group meetings (including aftercare services). A mixture of methodologies was used: participant observation, semi-structured interviews, focus group discussions with sociotherapy participants and sociotherapists, collection of testimonials and case studies, and collection of most significant change (MSC) stories. The latter technique aims to deliver bottom-up indicators for evaluating a program's impact (Davies & Dart 2005). We applied it with the aim to get the views of sociotherapists on the impact of sociotherapy. They were asked to identify what, why and how questions in the form of a story. In total approximately 60 stories were collected.

Outside the context of the application of this particular technique, stories about significant changes were told to us throughout our research by sociotherapy's different stakeholders, however without systematically addressing the three MSC questions.

FINDINGS

RECONCILIATION THROUGH SOCIOTHERAPY IN THE DIFFERENT CONTEXTS OF NYAMATA AND BYUMBA

Even though the Nyamata program started in 2008 with the same objectives as the Byumba program, reconciliation across ethnic divisions soon became a context-driven prominent subobjective in Nyamata. In this respect it was believed that sociotherapy could contribute to the government's efforts to achieve unity and reconciliation. In an evaluation of the MSC stories collected in Nyamata reconciliation emerged as one of the five bottom-up indicators, the other four being: regaining human dignity, a taste for life and community; regaining the will to work; personal healing; and community recognition of the impact of sociotherapy. However, even though reconciliation was singled out as the most prominent effect of sociotherapy in a particular story, it often featured as part of a complex of the other significant effects (as represented in the bottom-up indicators) sociotherapy may have. This was illustrated in the following two significant change stories of reconciliation. The protagonists of the two stories participated in the same sociotherapy group with 8 other people.

Out of the 10 participants 5 were Hutu and 5 Tutsi; 6 women and 4 men.

The story of Kwizera

Kwizera is a genocide survivor. He lost his own family (wife and 5 children) and many of his relatives. He felt a lot of anger towards all Hutus. He stopped attending church because Tutsis had been killed inside ‘his’ church and many Hutus are still going there.
The government built a house for him that he sold soon afterwards. Kwizera was living in a situation of hopelessness and was traumatized. He accepted the invitation to join sociotherapy. During the 2 first sessions he was very quiet, not happy at all, sitting in the same place as his ‘enemies’, the Hutu. It felt for him as if the facilitators had forced him to discuss with the people. Step by step, his facial expression of unhappiness began to change. During the fifth session he gained some trust in others. He opened up and shared his presentday life and past experiences with the group. The group started to care for him and recognized his losses. Kwizera, however, continued to show how he hated Hutus. He hardly looked at them and avoided them physically. The next session the group continued with discussing the themes social disconnection and togetherness. At the end of that session Kwizera said: “I can now accept and love Hutus, I have to move forward because the time I lost in despair is too much. I can now share drinks with them and I can now go to church again.” Nowadays, Kwizera is befriending Hutus. His sociotherapy group became known in his neighbourhood as a group of reconciliation. People wonder: “How is it possible for that survivor to work with others (Hutus)? For the survivor it is a resurrection.”

The story of Mahoro

Mahoro is an ex-prisoner who had spent 10 years in prison. He is married and father of four children. As a released prisoner he was always fearful that someone would be instrumental in sending him back to prison. Based on this fear, he experienced the invitation to participate in sociotherapy as a problem, wondering what was behind this invitation? After some time he confessed in a sociotherapy group session: “Before attending sociotherapy, my main problem was my perception of Tutsis as being in a favoured position. I mobilised my children to see Tutsis as our enemies. My concern was how to escape these Tutsis who can kill you, still as Interahamwe. For a long time I did not leave my house.” “Today we are together; we are visiting one another. We are participating in a reconciliation process.” In the next sessions he opened up, “They have become my true friends.”

When the group started the 12th session that Mahoro revealed all the secrets hidden in his heart regarding his fear and hate of Tutsis and started to feel released. “The teachings and trainings I got before sociotherapy to me were helpless … sociotherapy helped me to heal, to accept others and to be accepted; thus to reconcile.” “I was always worried, feeling that whoever looked at me saw in me a killer.”

The main action that helped Mahoro was the fact of sitting together and sharing in equality. From that point onwards mistrust of Tutsis began to decrease and finally disappeared once the fifteen sessions were concluded. Mahoro’s beliefs about the other ethnic group changed accordingly:

The group of Kwizera and Mahoro decided to continue to meet its completion of the official 15 sessions. They initiated a revenue generating activity which involved cultivating cassava, groundnuts, maize, sorghum and soja together. Their bi-monthly work on the field ends with a kind of sociotherapy session. During our participant observations of these working group meetings we found the group members talking, laughing and challenging one another; discussing what happened in the past, especially their experiences during the genocide and in the refugee camp where some of them had lived. The atmosphere in which these discussions took place was one of reconciliation and the group worked as a socially well-connected team. Soon the group elected a leading committee. Mahoro was elected democratically and unanimously as the chair of the committee.

Facilitators in Nyamata have identified many cases in sociotherapy like the ones presented above in which reconciliation is achieved. However, relationships are restored not only between Hutus and Tutsis, but also between husband and wife, between children and parents and between neighbours who belong to the same ethnic group.

In Byumba cases of reconciliation between members of different ethnic groups are less common than in Nyamata. A major reason is that while in Nyamata Hutus and Tutsis in terms of numbers are equally represented among the population, in Byumba the percentage of Tutsis among the population is relatively small. The latter means that it is not very likely that groups are mixed in terms of ethnicity. A second reason is that many people now living in Byumba lived in displacement camps or camps in exile during the genocide. In addition, the genocide that took place in Byumba was less severe than in Nyamata. This all means that many people in Byumba have little awareness of the genocide horror and its scope and that most people suffer from the memories of war and not of the genocide and according to facilitators, problems in day-to-day relations between people of different ethnic groups are not common.
Instead the social problems in Byumba which are prominent include the many widows, alcoholism, drugs, poisoning, polygamy, and domestic violence. It could be, however, that facilitators out of fear for being accused of genocide ideology shy away from identifying and addressing directly ethnicity-related issues in sociotherapy groups.

The lack of knowledge of what happened during the genocide in the county is one of the reasons that until recently the attendance of government organized activities during the annual mourning week (April 7-13) - such as memorial conferences - in Byumba region was very low. However, the mourning week used to generate a variety of problems for people on an individual and societal level. Sociotherapy staff and facilitators noticed that on an individual level there is an increase in emotional problems, suffering from bad memories, flashbacks, a sense of social isolation; and a loss of appetite. There are people who switch off the radio and TV during the whole period to protect themselves from bad memories. Within the communities social relations deteriorate, one hears more provocative words, and distrust (keeping a social distance), suspicion and individualism increase.

After a few years of experience with sociotherapy the leading team of the program decided that some extra efforts should be made to address the problems identified. Sociotherapy had proven to be able to bring togetherness, such as coming together, sitting together, thinking together, challenging each other together, solving a variety of issues together, working together, and mourning/socializing together. The aim was to capitalize on these achievements during the mourning week. Sociotherapy facilitators were supported in giving talks during memorial activities. Furthermore, facilitators and (ex-)participants were stimulated to undertake the following activities: encourage people to attend memorial conferences organized around the villages; pay visits of moral support to sociotherapy participants, their families, friends and neighbors; give social assistance to those in need (activities related to agriculture and animal-rearing or domestic activities); and actively engage in socio-economic undertakings (savings and crediting). An effect of these extra efforts to put sociotherapy in practice was that the last few years, to the pleasant surprise of the local authorities, the attendance of memorial conferences has tremendously increased. The places where these conferences are held are now filled up with people. Another effect is that retraumatisation of (ex-)participants has decreased, as the story of Constance testifies.

The story of Constance
Constance is a 67 year old lady, a genocide survivor. Each year during the memorial period she spent around two weeks in hospital because of problems of re-traumatisation. In 2007 she joined sociotherapy. There she found a new family. During the 2008 mourning week she went to hospital as usual. Members of her sociotherapy group with whom she continued meeting visited her during her first day in hospital, bringing food and drinks for her with them. The result was that Constance expressed the desire to go home. After some pressure from of the group on the hospital staff, Constance was allowed to leave the hospital and go home with the group the same day. The subsequent two years she experienced no specific problems and could remain home during the mourning period.

DISCUSSION

THE RELATION BETWEEN HEALING AND RECONCILIATION

In the scholarship on post-conflict societies, healing is frequently used in a psychological sense and juxtaposed to reconciliation defined as social reconnection. In the context of sociotherapy healing and reconciliation are intricately interconnected. There seems to be no unilateral causal relationship one way or the other. What people in Rwanda suffer from most is the damage done by the political violence and its legacies to the fields of social relationships.

The primary aim of sociotherapy is to repair this damage. Sociotherapy creates a social space in which people come out of social isolation and start to ‘dialogue’. They begin to regain the freedom to speak and act in the contested space of intersubjectivity. It is in the phase of care that participants start to feel that trust and safety in social relationships can be restored, which is experienced as a turning point in their lives towards healing and reconciliation. It is particularly in this phase than one acknowledges that the other needs care too, including persons who were seen as ‘the enemy’.

Sociotherapy is considered by its participants as a medicine for the heart, a heart that is particularly suffering from social disconnection and needs ubwiyunge to really heal. A restoration of this disconnection solves other problems in its wake. Our research results indicate that people who do suffer psychologically from crises due to the legacies of the war and genocide mostly do not single out psychiatric symptoms as the key of their suffering but emphasize problems in social relationships. The ‘healing’ of social relationships seems often to be accompanied by a decrease of psycho-trauma symptoms and symptoms of depression. Our research supports the implication of the study on cultural differences in personal.
identity in PTSD conducted by Jobson and O’Kearny (2008) that in interventions there may be “a lesser role for cognitive reframing of self-schema for those from interdependent cultures” and a need for “greater emphasis on the impact of trauma on the public/collective aspects of self” (Ibid.: 106). Sociotherapy in Rwanda acknowledges this impact through its method.

Sociotherapy does not present itself as a program of forgiveness and reconciliation as so many other programs in Rwanda do. In Rwanda, reconciliation is not only the official policy of the government, it is also “the mantra of Western humanitarian organizations” (Stansell 2009:35). According to a genocide survivor living in Nyamata, quoted in Hatzfeld (2009:18), it is not the people in Nyamata who speak about forgiveness. It is the humanitarian organizations that do so. “They are importing forgiveness in Rwanda, and they wrap it in lots of dollars to win us over. There is a Forgiveness Plan just as there is an AIDS Plan... As for us, we speak of forgiveness to earn their good opinion – and because the subsidies can be lucrative. ... But when we talk among ourselves, the word forgiveness has no place.”

In sociotherapy the word forgiveness was regularly used. Either participants said that they followed the advice from the group to forgive those who wronged them or they said spontaneously in the group that they had forgiven. Without any specific teaching about reconciliation sociotherapy proves to effectively facilitate processes leading towards reconciliation, whether or not preceded by forgiveness. This does not mean that sociotherapy is always successful in this respect. Not every participant will ‘open up’ and start sharing what is in his or her heart, forgive, and achieve reconciliation (whether in the form of kubana or ubwiyunge). Sociotherapy does not force anyone to forgive, apologize or reconcile. It creates a safe space where participants experience being cared for, which may facilitate a process leading towards reconciliation. In many NGO program that aim specifically at reconciliation, participants receive training and education and are more or less forced to forgive or apologize. This approach is similar to the teachings and sermons related to reconciliation in churches.

Brudholm (2006) observes that today in globalized responses to mass atrocities there “is a lot of attention to forgiveness, conciliatoriness, and other responses that are commonly considered appropriate or admirable. Yet, little interest is left for considerations of the possible value and legitimacy of victims’ ‘negative’ emotions. They are typically only considered in their function as a negative force to be overcome, labelled as hindrances to reconciliation, morally inferior, irrational, immoral or pathological” (p. 9). In the footsteps of the Jewish writer Jean Améry, who survived the Nazi death camps, Brudholm (2008) argues that “the resistance to forgiveness or the expression of resentment can be consistent with a striving for reconciliation and a mutual recognition of humanity; that is, exactly, what was excluded from the TRC [Truth and Reconciliation Commission] process in South Africa” (p. 78). It is excluded as well from government programs, many NGO interventions and most religious approaches regarding reconciliation in Rwanda. Like in the TRC in the implementation of many reconciliation programs in Rwanda subtle or covert pressure to forgive and apologize are used. Whether, to what extent and in which circumstances this becomes an impediment to mental and physical recovery instead of contributing to healing and reconciliation in Rwanda would need systematic research.

While all resentments should not be seen as unhealthy and negative emotions such as anger should not be pathologized beforehand (Brudholm 2006, 2008), mental health professionals should be reflective regarding their pathology focus. Sociotherapy works in line with the approach advocated by Walsh (2007). She argues that mental health professionals can best foster trauma recovery by shifting from a pathology focus and expanding the predominant individual treatment by broadly contextualizing the distress in the traumatic experience and tapping strengths and resources in relational networks to foster healing and posttraumatic growth. An intervention such as sociotherapy helps to build these networks where they were destroyed by war and genocide and approaches distress in historical, socio-economic, cultural and political context.

We agree with others (for instance, Buckley 2005; Staub et al 2005) who have studied the impact and flaws of gacaca and other formalised national scale programs aimed at healing and reconciliation that these programs should be complemented by interventions situated in local communities. The truth finding and justice of gacaca should be complemented by the construction of care and social truth which a program like sociotherapy can provide. Social truth refers to “the dialogic process of sharing experiences with the aim of transcending the divisions of the past by carefully listening to the contexts and motives of all involved” (Buckley 2005:6).

What is specific of sociotherapy in contrast to many reconciliation interventions is that the people who meet in the groups live in the same neighbourhood. This means that they more or less know each other’s factual truth, even if this truth is not discussed in public or in the semi-private social space of a sociotherapy group. What people do say in the group is evaluated
by group members for its factual truth. Through discussion in an atmosphere of love, care and respect each other, and when needed challenge each other to say the real truth. This way of proceeding may remind people of the ku karubanda, bose babireba practice of ancient times, where the accused and accuser were obliged to say the truth surrounded by spectators and could not hide anything out of fear for extreme consequences, which could be even death. Sociotherapy may also remind people of traditional gacaca. However, people also appreciate the way sociotherapy differs from traditional gacaca, in the sense that the principles of equality, democracy and individual responsibility (for instance to contribute to the case brought forward) as they are applied in sociotherapy were not as thoroughly applied in traditional gacaca.

CONCLUSION
In this article we have presented community-based sociotherapy in Rwanda in the context of a history of political violence and multiple traumatic experiences generated by this violence and its aftermath and also in the context of various interventions implemented to help Rwandans to move forward to healing and reconciliation. We conclude that for Rwandans to live together again in relative peace that is experienced as such in their heart, interventions aimed at justice should be complemented by interventions aimed at care on the level of families and communities. Healing from psychotrauma on an individual level is experienced by the informants of our study as intricately related to healing of social relations. Our study suggests that to exert pressure to forgive and reconcile may at the most lead to thin reconciliation. We suggest that in psychosocial interventions negative emotions should not be approached as per definition pathological and individual and that pathology-focused psychotrauma healing approaches should at least be complemented by multi-systemic resilience oriented healing approaches. Our study suggests that in general people profit more from the latter than the former.

ACKNOWLEDGMENTS
We gratefully acknowledge the financial support of the Dutch NGO, Cordaid which supported the sociotherapy programs, the sociotherapy program staff who facilitated the research and our informants in the field who generously shared their experiences with us.

REFERENCES


Introduction

The refugee identity is to a large extent marked by trauma. This includes the traumatic violence that so often precipitates the condition, as well as the events that characterize exile existence notably; fear, insecurity, and despair.

By definition, refugees are people outside their state of origin or of residence, and they cannot return for fear of human-rights related persecution. Mental health practitioners and scholars the world over have attempted to address the myriad of psychological disorders orchestrated by the trauma associated with living in refugee communities. Psychologists and psychiatrists practicing and conducting research in East and Central Africa find themselves in the middle of this ongoing professional struggle to provide mental healthcare in the form of appropriate psychological treatment to refugee resulting from ethnic and political instability.

The refugee problem in East and Central Africa has happened in different waves since the early 1970s and is grounded well outside the scope of mental health. The resolution of the refugee problem resides in political reconciliation in countries of origin. The "front line" for giving "treatment and management of mental health problems" in refugee communities is of course, in neighboring host countries. Almost since her independence, there has been no country more prolific in hosting refugees in the region like Tanzania.

In the early 1970s, Tanzania opened her borders to Burundian Hutu refugees. The Tanzanian government granted them land to farm and they have since resided in long term refugee settlements.

Since 2002, the Tanzanian government working hand-in-hand with United Nations High Commission for Refugees and destination countries have repatriated hundreds of thousands of Burundian and Congolese refugees. However, several hundred thousands of refugees still remain in Tanzania, undergoing an expedited naturalization process to obtain full Tanzanian citizenship. In so doing, these individuals are expected to remove themselves from camps and settlements, and to find residences in other regions of Tanzania.

Consequently, fragile communities of former refugees have resulted. Several generations of Burundian Hutus were born in refugee settlements. To a significant extent, their identity is bound up with stories told of the violence leading to their emigration, and their ongoing life in exile (Malkki, 1995). Many have left camps and settlements unlawfully over the years and live in fear of being discovered in the country's larger urban areas. For them, paranoia and suspicion are a way of life (Sommers, 2001). Coupled with this, such communities remain troubled by the profound
psychological impact of genocidal violence and political victimization. This presents a significant challenge for Tanzania’s existing mental health infrastructure and institutions.

**Current Facts on the Ground**

In the wake of the Arusha Peace Accord of 2002 that the transitional Burundian government signed with Tanzania and the UNHCR, a tripartite agreement to begin the process of repatriating Burundian refugees was set in motion. In the years following that agreement, most refugees within Tanzanian borders have either chosen repatriation or naturalization. Each of these paths, however, occasioned additional psychological trauma.

For those returning home (including nearly 400,000 Burundian refugees since 2002), the process has been facilitated by cooperation between the host country and the destination country governments, as well as UNHCR staff in both countries. Included amongst those choosing repatriation are those who had lived in Tanzania for more than three decades (Refugee #2 (anonymous, personal communication, August 3, 2008). Reasons for those refugees who decided to leave exile include; the longing for a place they still consider home, the possibility of seeing families that had been left behind, and the promise of better economic opportunities. However, there were also very real fears, particularly regarding security, safety, and land rights (Refugee #1 (anonymous), personal communication, August 4, 2008).

**Figure 1: Burundian Refugees Returning Home (August 2008)**

For those who decided to remain in Tanzania, the UNHCR, working with the Tanzanian government streamlined the process to apply for citizenship. In older refugee settlements, this meant naturalization applicants clearing most legal and administrative hurdles to citizenship (save for a police background check) in approximately half an hour. Lawyers were provided to applicants on site (See Figure 2).

**Figure 2: UNHCR Shelter at Ulyankulu (August 2008)**

**Figure 3: Naturalization Process at Ulyankulu (August 2008)**

After living in refugee settlements for decades within Tanzania but never fully assimilated into Tanzanian society, this naturalization process has been in itself anxiety provoking for many. When asked, applicants seeking naturalization expressed concern that they would not meet the criterion for citizenship. However, an interview with a key informant established that there was no ostensible foundation for this concern. When confronted with the idea of moving away from the settlements to other regions, few were prepared. While filling the UNHCR questionnaires that asked about their preferred provinces for resettlement, most struggled to bring to mind the requisite number and nearly all defied instructions and selected provinces of their then residence (interview). One of the most pressing issues regarding this population has been the potentially traumatic impact of again being forced to leave their homes for strange lands. While the overarching plan for resettlement involved both the UNHCR and the United Nations Development Program, lingering psychological disorders stemming from previous trauma have been exacerbated during the transition period.
Mental Health of Refugee Community

It is therefore highly desirable to acquire a robust understanding of the overall mental health of the refugee population. Conducting the quantitative psychological studies necessary to obtain such information in East Africa is hampered by resource constraints. However, there have been some important efforts made at documenting the mental health conditions of refugees in the region. While these are few in number, they are reason both to hope and to call for additional studies of this sort.

Owing to the problem of eliciting empirical data, studies concerning the mental health of refugee populations in East Africa tend to deal with only convenient and accessible populations. For instance, Cohen et al. (2009) base their analysis of Post Traumatic Stress Disorder upon a study of Rwandan women who had been raped during the 1994 genocide, most of whom (77%) had subsequently contracted HIV/AIDS. While their work makes an important contribution to the study of the intersection of public health and mental health concerns in refugee populations, their data regarding PTSD levels reflects both the initial violent trauma and the ongoing implications of HIV infection (Cohen et al., 2009). Their results of this demonstrates that even more than a decade after the traumatic event, the prevalence of PTSD symptoms in the population they studied is very high (58%) (Cohen et al., 2009). While the conditions under which the study was undertaken are less than ideal for isolating the PTSD’s impact upon the mental health of refugees in East Africa, its results are at least suggestive of a pervasive problem. Similarly, in a smaller study, Schaal, Elbert and Neuner, (2009) observed that all the twenty-six orphans of the Rwandan genocide they studied displayed PTSD symptoms.

In 2002 the Tanzanian Ministry of Health was tasked with addressing the mental health needs of those residing in several refugee camps. The primary purpose of this effort was to gauge the mental health requirements of those in these particular camps, thereby gaining a better understanding of what efforts might be made to administer proper mental health care in all refugee camps and settlements within the country. In order to do so, refugees were interviewed about their experiences, including both the events that lead to their removal from their homes as well as their lives within camps. Respondents detailed the traumatic violence that drove them to camps in Tanzania’s camps. In the process of determining the mental health needs, a number of refugees were interviewed and focus group discussions were held. Most of those interviewed had either; experienced physical or sexual violence, or had witnessed such traumatic events being inflicted on family members and friends, or had found themselves forcibly parted from loved ones.

In the course of interviews, it became clear that the realities of life in exile were also a source of psychological distress. Many felt vulnerable to exploitation, particularly on the basis of ethnicity. Respondents also reported a constellation of fears including repatriation, separation from family, restriction of movements, memories and worries of family left in home countries, poverty, resentment and stereotyping by the host country’s citizens, language barriers, and education for their children (particularly girls).

Even the younger generations who were born in Tanzania and who had never set a foot in their country of origin or let alone experience a traumatic violent event in their exile had not been spared psychological trauma. Those born and raised in refugee camps and settlements found themselves subjected to challenges of life like; lack of basic security, various forms of social marginalization, and a curtailing of hopes for economic advancement. The younger generation had also suffered indirectly from violent events taking place before they were born. Psychological trauma, when occasioned by genocidal violence is frequently passed down generationally (Kaplan, 2006; Sossin, 2007; Goldenber, 2009). It is therefore not surprising to see changes in parenting style in the wake of trauma in refugee communities. While children growing up in these contexts develop remarkable coping mechanisms, this is often marked by disorganized attachments to others and future difficulties in fostering nurturing relationships (Sossin, 2007).

Treatment

Mental health experts have developed several treatment strategies to meet the particular needs of refugee communities. These approaches generally conform to two broad paradigms. Community-based approaches have found significant support amongst mental health professionals and policy-makers. For other psychologists and psychiatrists, treatment protocols that derive from the cognitive-behavioral model seem to be the most promising.

Advocates of a community-based approach point to the need for political reconciliation as part of the healing process. This implies that those refugee survivors would be enabled to understand that their experiences and the crimes committed against them had been acknowledged by society. It also indicates that upon this acknowledgement, genocide victims would find a way to forgive perpetrators of the genocide (Staub, Pearlman, Gubin & Hagengimana, 2007).
At the same time, community-based treatment approaches offer significant practical benefits. refugee camps and settlements are large population concentrations, and therefore present significant challenges to mental health infrastructure in parts of the world with already limited resources. Reaching as many as possible given constrained resources is therefore a primary consideration. Community-based therapy is ideally suited to meeting this challenge.

In a seminal study in the field, Staub et al (2005) argued that not only is reconciliation a prerequisite for real psychological healing, but also a fundamental step in establishing lasting peace in war-torn regions. The authors conducted their study among Rwandan refugees with the aim of demonstrating the concrete psychological benefit of community-based therapy in both victims and perpetrators of the 1994 genocide (Staub et al, 2005). Unique in its conception, the authors of the study undertook teaching community leaders as well as religious leaders in a series of psycho-educational lectures in a nine-day training program. Community leaders learned about the nature of the psychological impact of trauma, the needs of trauma victims, and the productive value of the sharing of painful experiences (Staub et al, 2005). These leaders then brought this information to their communities. Interestingly, the authors measured psychological change in those communities within which these leaders served, with a control group represented by communities served by staff who had not undergone through training. Evaluation of the data is somewhat challenging, given the fact that the nature of the different communities was far from homogenous (some were overtly religious while others were more akin to support groups). Even still, the data indicates that treatment reduced the overall population's trauma symptoms and increased willingness to reconcile (Staub et al, 2005).

Studies that adopt a cognitive-behavioral approach have attempted to measure the success of efforts to change the way trauma victims remember and process violent life events. One recent study has demonstrated the potential of this treatment paradigm's application to youth survivors of the 1994 Rwandan genocide (Sezibera, Van Broeck & Philippot, 2009). The study evaluated the extent to which cognitive-behavioral intervention might succeed in displacing harmful ruminations about violent trauma in younger refugees suffering from PTSD.

The authors assert that PTSD symptoms do not necessarily diminish in time with genocide survivors, but rather persist, exacerbated, by memories and associated thought processes that reintroduce the trauma, and design a treatment program aimed at disrupting this cycle.

This treatment program, consistent with the cognitive behavioral paradigm, included a psycho-education session about PTSD, and weekly 2 hour treatment sessions over 10 weeks. Also, again in keeping with the cognitive-behavioral approach, patients were assigned significant amounts of therapeutic work to complete between sessions. Specifically, patients were asked to critically evaluate what sorts of coping strategies they employed, what problems these coping strategies occasioned, and what sort of more productive actions they might take (Sezibera, Van Broeck & Philippot, 2009). Despite the very brief therapeutic intervention, the study documented significant decreases in PTSD symptoms (Sezibera, Van Broeck & Philippot, 2009).

Though there are many studies concerning the effectiveness of the treatment of trauma occasioned by genocide in other world regions that are somewhat problematic in their application to East Africa, given the different cultural and historical contexts. Even still, those that highlight the treatment of victims from recent Baltic conflicts may be useful. At the very least, there are strong parallels to be drawn between the ethnic cleansing in Bosnia in the 1990s with ethnic violence in East Central Africa in the 1990s and early 2000s. Survivors of the former represent a population in another part of the world that has received effective psychological treatment. Studies such as Smajkic et al. (2001) in which pharmacological treatments proved effective in treating refugees suffering from PTSD point out what successful outcomes mental health professionals in East Africa might anticipate if resources were available.

To date, most efforts to meet the treatment needs of Tanzania’s refugee population have not used pharmacological regimens, but have focused on various forms of conventional psychotherapy. Schaal, Elbert, and Neuner’s (2009) study of Rwandan genocide orphans used narrative exposure therapy to alleviate PTSD symptoms. While their symptoms did not go away entirely, they did make substantial progress that remained after a 6 month follow-up visit. On a broader, community level, Staub et al. (2005) enjoyed statistically meaningful success by enlisting community and religious leaders as partners in the therapeutic process. The Tanzania’s Ministry of Health (MOH) has itself taken steps to meet the mental health needs of the country’s refugees.
Early efforts at doing so have focused on establishing the foundation for lasting service to what is now a more or less permanent part of Tanzanian society (as opposed to short-term, limited studies). Initially, the MOH created a network of primary health care workers skilled in assessing and treating trauma and psychological disorders. The MOH worked to enhance the capacity of communities to recognize the psychological distress caused by trauma by providing training. The MOH also recruited refugees themselves who worked to educate their peers regarding psychological distress. Lastly, the Ministry of Health instituted a better system of documentation and referral to treat refugees suffering from psychological disorders demanding more clinical intervention (Mbatia and Hogan, 2005).

**CONCLUSION**

Since 2006, Tanzania has closed nearly all of its refugee camps and long-term refugee settlements. As of April of 2010, 162,000 refugees had been naturalized (UNHCR, 2010). While this represents an amelioration of their nationless status, the legacy of trauma troubling the population’s mental health remains a challenge for the country for the foreseeable future.

The scope of the problem is sufficiently clear even in a situation where there are difficulties of systematic evaluation of the refugee population by trained mental health professionals. Studies like that of Cohen et al. (2009) at least suggest that a substantial proportion of genocide survivors in East Africa continue to suffer from trauma that took place more than a decade ago.

Likewise, it is clear that treatment of a variety of sorts can be effective. A pharmacological treatment program administering anti-depressants to PTSD sufferers, as was the case in Bosnia, might be the most expedient approach (Smajkic et al., 2001). Unfortunately, drugs in East Africa are too often in short supply. Perhaps more practical are programs that support mental health professionals intervening through other therapeutic means.

This article describes several possible alternative treatment methods, all of which might be of use in addressing the mental health challenge facing Tanzania’s refugee community. Ruminative-focused cognitive-behavioral therapy has already proved effective in limited applications, however it does require a substantial commitment of mental health personnel (Sezibera, Van Broek & Philippot, 2009). Community-based approaches may yield the most modest gains in improved psychological functioning, but since community leaders are used to deploy the therapy itself, more individuals can be reached with fewer resources (Staub et al, 2005). Indeed, the Ministry of Health has already adopted aspects of this model.

Ministry of Health and Social Welfare mental health services continue to labor to treat refugees who will remain within the country’s borders. They do so with the knowledge that their efforts will aid the peaceful assimilation of refugees into a stronger and more cohesive Tanzanian society.

**REFERENCES**


BACKGROUND

In 2005, the civil war in northern Uganda had lasted 20 years and was still on-going. During the armed conflict, up to 2 million people were displaced and the most affected districts were Gulu, Kitgum and Pader (MSF 2004). To protect people from the dangers of armed conflict, the state ordered civilians to move to Internally Displaced Persons (IDPs) camps or protected villages. The reality is that even in these so-called protected villages, people were exposed to dangers of insecurity including child abductions, gender-based violence and infectious disease epidemics.

For example, Human Rights Focus (Hurifo, 2002:16) reported that 730 children were abducted in Pajule, 250 in Puranga, 502 in Putongo, and over 600 from Atanga in Kitgum district.

Human Rights Watch (HRW) has documented the Lords Resistance Army (LRA) attacks, abductions, willful killing of civilians, the burning and looting of villages and homes and ambushes of vehicles. In 2002 the LRA was reported to have killed and injured hundreds of civilians in isolated villages, IDPs and Sudanese refugee camps (HRW 2005:15-23).

The United Nations Fund (UNICEF 1998; 2005) reports that children account for approximately three out of every four abductions. Most of these children were between the ages of five and seventeen. The children were abducted at night when the LRA raided villages, camps, schools and churches. As a consequence, many children abandoned villages and sought refuge in neighbouring towns. In the context described above many children suffered from various forms of psychological distress. It is the aim of this article to present and critically analyse how the children managed their complaints symptomatic of psychological distress within the context of war-torn northern Uganda. Their distress is generated. Where relevant gender differences will be highlighted.

*Correspondence:
Grace Akello, PhD
Gulu University, Faculty of Medicine
P.O. Box 166, Gulu.
Akellograce@hotmail.com
METHODS
Study area
This study was conducted in Gulu Municipality and in camps which were located within the safe zones. In 2004 and 2005 when this study was conducted, safe zones were defined as areas within a 7 km radius from Gulu Municipality.

Over 500 children participated in this study. These children were aged between 9-16 years and met one or more of the following criteria: living in child-headed households, attending schools in IDP camps, spending nights in night commuters’ shelters. In addition, some of the children interviewed took care of adult kin who were sick due to HIV/AIDS and registered with Lacor Hospital’s President’s Emergency Plan for AIDS Relief (PEPFAR) or World Vision’s Antiretroviral Programme. Owing to the high mobility of children, not all participated in all the study activities.

Table 1: General characteristics of children who participated in this study

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sample size</th>
<th>Age</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>88(53.3)</td>
<td>13.4</td>
<td>6.27</td>
</tr>
<tr>
<td>Girls</td>
<td>77(46.7)</td>
<td>13.4</td>
<td>6.28</td>
</tr>
</tbody>
</table>

The children who reported the most harrowing experiences were taken to the regional psychiatrist for review and counselling. All names of children used in this article are pseudonyms to ensure anonymity.

FINDINGS
Results suggest that girls were three times more likely to mention an experience with stomachache within a one month recall than boys, with a statistically significant difference (p<0.005).

Stomachache covered a wide range of problems including urinary tract infections, indigestion, diarrhoea, and for girls painful periods. This partly explains the gender difference regarding the prevalence of stomach ache. However, for both boys and girls some stomach aches were symptomatic of more complex forms of psychological distress and our aim is to address this complaint as such in this article. There was no statistically significant difference in boys’ and girls’ mentioning of complaints such as persistent headaches (p=0.58) and pain in the body (p=0.39).

Quantitative data: Common forms of somatic complaints possibly symptomatic of psychological problems and quests for therapy

Table 2: Prevalence of complaints possibly symptomatic of psychological distress (N=165)

<table>
<thead>
<tr>
<th>Symptoms of illnesses</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
<th>P-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amwoda ici (stomach aches)</td>
<td>22</td>
<td>61</td>
<td>83</td>
<td>&lt;0.005</td>
</tr>
<tr>
<td>Abaa wic lela (persistent/severe headache)</td>
<td>36</td>
<td>35</td>
<td>71</td>
<td>0.58</td>
</tr>
<tr>
<td>Kuma rem (pain in the body)</td>
<td>17</td>
<td>11</td>
<td>28</td>
<td>0.39</td>
</tr>
</tbody>
</table>
In general, Piriton and Valium were popularly called yat nino (medicines for sleep). The two pharmaceuticals indeed have sleep-causing properties much as for Piriton, the sleep-causing effect is viewed as only a side effect since its main purpose is to counter allergic reactions. Children also indicated using yat nino to alleviate pain in the body such as abaa wic lela and common colds. With the exception of Valium – for which boys’ reported use exceeded that of girls (P=0.01) – there was no other statistically significant difference between boys’ and girls’ use of pharmaceuticals for these complaints within a one month recall.

Qualitative data: Psychological complaints and quests for therapy

It was only during the qualitative data collection that children spoke of complaints that directly referred to psychological distress. In the next sub-sections we will present these complaints and the various ways that children tried to minimise them.

Sleeplessness

In November 2005, eight boys and two girls of primary school age were observed in three drug shops. They purchased yat nino (medicines for sleep). Two nurses and one drug shop owner (without training in biomedicine) inquired whether they wanted Piriton or Valium; five of the boys bought four tablets of Valium each for 200 Shillings (0.087 Euro). Children told how they used Valium and Piriton for a certain type of painful headache, which often affects only one side of the head. In a group discussion, however, three boys mentioned that “If Piriton and Valium are yat nino, then their only use is when someone needs to sleep”. Further, one fourteen year old boy stated in one group discussion, while eight others agreed in unison, “This is because at ‘baghdad’ [euphemism for night commuters’ shelters] were many mosquitoes, lice, and bedbugs; we sleep on the cold cement floor, tents are torn, and when it rains sleeping in a cold, damp place is difficult. We therefore need yat nino to make us sleep”.

A slightly different explanation was offered by children at one of the night commuters’ shelter - Noah’s Ark. Many of them indicated the need for yat nino since at the shelter many children cried, shouted, and others, usually former child soldiers, seemed to fight with invisible people in their sleep. Other children, when asked about their dreams, told how they were dreaming of being abducted, and how in their sleep, they fought the many or latino lum (soldiers or other LRA abducted children) who wanted to take them to the bush. Three ex-combatants related having given up on the idea of taking yat nino, since they were not effective anymore. For example one ex-combatant narrated:

For the first few days, after taking two and sometimes three or four tablets of yat nino, I could sleep. [But] after a few days of taking that yat nino, I would remain awake all night. I still have cen disturbances whether I swallow four or more Valium and Piriton at the same time.

Cen and tipo (evil spirits)

Children used the terms cen and tipo interchangeably. Cen refers to evil spirits, which present as dead people in nightmares: or as dead people seeking revenge because they suffered a wrongful death or burial. Tipo refers to images of deceased close kin.

Cen and tipo (evil spirits)

Children used the terms cen and tipo interchangeably. Cen refers to evil spirits, which present as dead people in nightmares: or as dead people seeking revenge because they suffered a wrongful death or burial. Tipo refers to images of deceased close kin.

In relation to nightmares, two children interchangeably referred to disturbances by cen and tipo. Tipo could turn into an evil spirit depending on the frequency with which it appeared and the disturbance it caused to its victim.

Fifteen year old girl explained this distinction, upon inquiry into the persistent nightmares caused by her deceased father’s spirit as follows:

At home my mother often corrected me if I talked about seeing cen of my late father in my dream. She always told me that the spirit of a close relative who did not want to harm me is tipo and not cen. But since I had reached a level of not sleeping and screaming in my sleep, even during the day, due to my late father’s disturbance and his demand for guru lyel (last funeral rites), even my mother started...
referring to it as cen. I suffered very much during that time due to that tipo, until my mother and lodito (clan elders) organised the ceremony of ryemo cen/tipo (to chase away or get rid of evil spirits) at Karuma, involving the strongest ajwaka (indigenous healer).

Cen can be viewed as the epitome and culturally appropriate symptomatology of distress in northern Uganda. There are overlaps between how cen was presented by children and the documented literature pertinent to the symptoms of Post Traumatic Stress Disorder (PTSD) – such as nightmares, hypervigilance, fear, and persistent headaches – but for purposes of clarity cen will be adopted to refer to the specific idiom of distress through which displaced children experienced and explained some of their emotional suffering.

Children identified cen as a core cause of sleeplessness during a workshop to discuss severe wartime experiences. Although children perceived the severe and more persistent forms of cen to be also present during the day, commonly cen disturbances were described as occurring during sleep.

**Quests for therapy for tipo and cen**

After a ‘deliverance session’ aimed at alleviating experiences with tipo, at a healing crusade organized by Life Line Ministries Church, fourteen year old girl elaborated on her experience during the session as follows:

> I always have dreams about my late mother’s tipo coming for me. She appears while I am asleep to tell me to go and join her. When I told the pastor that story, he prayed for me and chased that Satan. He also told me that every time I see the cen of my mother I should tell her I do not know her. This is because she decided to die and leave us to suffer. I should also call fire from heaven to burn her.

In five workshops on severe experiences and medicine use in wartime, held with a total of seventy-seven children between the ages of eight and sixteen, children presented atika plants as an important medicine. The only exception were five children who attended Pentecostal church services and told they had been, since using atika plants around their sleeping place would ensure that the cen they picked up during such horrific scenes would not disturb them.

Ex-combatants used atika plants to prevent them from reliving and re-experiencing the horrendous acts they committed themselves while in captivity to stop being disturbed by the spirits of people whom they killed. “Such spirits are very violent. They come in your sleep, even during the day, with a gun, sharp knives, and sometimes they struggle to remove a gun from you in order to kill you in a dream. So you need these plants”, argued one female ex-combatant in an interview. In Akello et al. (2006) the experiences of former child soldiers with the cen of people they had killed are extensively discussed.

In the subsection on stomachaches below we shed more light on girls’ use of atika plants against the visions of huge men who want to rape them in their sleep. However, boys also used atika plants when they could not sleep due to war related events, after Valium had failed them. Two boys discussed how their dead parents often demand that they perform the guru lyel ceremony, but they did not yet have the money; so they used atika plants to ward off such demanding spirits. Overall, indigenous practices seemed to offer solutions that help people to cope with the symptoms, but were not able to remove the causes. This led to desperation, as became clear in a focus group discussion with twelve to fifteen year old children who recommended that if cen did not respond to all these practices, the affected child should join the armed struggle since cen fear anyone with a gun. In effect, it is plausible to argue that the preceding statement suggests children’s consideration of addressing core causes of emotional distress. As explained elsewhere (Akello et al. 2006), exclusion and discrimination of ex-combatants by the communities in which they were reintegrated contributed to children’s distress. Subsequently, such distress could be minimised through former child-soldiers becoming part of armed forces where they are accepted and not constantly criticised.

**Persistent headaches and pain in the body**

In two focus group discussions girls aged twelve to fifteen years made a distinction concerning ‘normal headache for malaria’ and ‘headache which pains only one side of the head and often leads to bleeding through the nose’, differentials of which in medical phenomenology would be migraine headache or sickle cell disease (Ovuga and Acuda 1985). The latter is similar to the one described by the two other children with epilepsy. Although this headache was managed with various types of paracetamol containing analgesics including Panadol, Action, Hedex, and Painex – sometimes by taking more than the recommended dose, such as three or four tablets of Hedex instead of two – and or combined with atika plants, the distress from these headaches was persistent and severe, and there was often no specific cure.
Fourteen year old boy wrote about a particular headache as follows:

"I had a headache problem for some time. My head pained so much. I did not go to hospital but my good friend bought for me Action tablets to take. It cured. But the pain came back. Each time when I have money I buy Action tablets for that headache. For many months now, I have that headache."

Five children taking care of their sickly kin due to HIV/AIDS described their experience with "severe persistent headache which is not due to malaria".

"Perhaps it is the cen/Satan that makes my mother sick which is disturbing me as well" said Abonga. As he frequently told, "Each time a pastor from Bridge Builders Church comes to visit us at home, he prays for my mother and for me. He often prays to chase away the Satan which disturbs our family".

Fifteen year old boy, who was living under very stressful family conditions, narrated how he had "very painful headache and pain in the body".

For this painful headache he had frequently bought Panadol at the beginning, but he did not use it anymore since it had stopped being effective. Instead, he now bought strong medicines for headache such as Action, Hedex, and Painex. Sometimes he bought these medicines in conjunction with Valium. As time went on, he even started taking three or more pain killers tablets since the headache had become very strong. Here is how the boy discussed his experience with persistent headache:

"This headache which I've had for the last three months is not the one for malaria. It starts with something moving around my body. Such a thing is painful and when it reaches my head, I feel intense headache. I often swallow Hedex or Action, sometimes three of them at a go, but the headache only subsides. A week ago when I went to Layibi Health Centre, I told the doktar that instead of giving me medicine for malaria, let them gi pime ikum ki wek gi nongo two en ni -(perform all possible laboratory tests to find out the illness causing the headache). Instead, he wrote for me [prescribed] to buy chloroquine, Panadol, and Fansidar for malaria."

Four ex-combatants of primary school age shared their experiences with painful headaches as 'headache which affects only one side of the head', or 'headache which only reduces when you take Action and Hedex, but it still comes back'. One former child soldier who extensively participated in the ethnographic study linked her headache to constant disturbances by cen:

"It is mainly the cen of the people (even children) I killed without cause, which disturb me. The cen of such children can really disturb. Sometimes, the cen can just sit on your head for a long time, thereby causing headache."

Generalised body pain complaints were even more common in children taking care of sickly kin with HIV/AIDS. For example, twelve year old girl and ten year old boy variously complained of pain in the body, "probably because we are always oppressed by Satan". The ten year old boy often related how his mother frequently invited the pastor of Bridge Builders Church to pray for her and her family. The pastor always prayed and chased away Satan which tormented this family. Two children aged twelve and thirteen years, shortly after they had been forcefully evicted from their hut in Pece due to failure to pay rent, also talked about having bodily pain. One of them attributed her body pain to the likelihood that she and her siblings had malaria, since they had spent nights in an overcrowded night commuters' shelter where there were many mosquitoes. We will come back to this complex overlap of symptoms between psychological distress and experiences with infectious diseases. Since infectious diseases were also highly prevalent during wartime, a single encounter between the first author and a child (or professional healthcare worker) was not sufficient to determine whether a presented illness episode was due to malaria or emotional suffering. The narratives we present here are exemplary cases, where extensive interaction with the children involved made a hypothesis of psychological distress plausible.

**Stomach aches**

In the clinics, the first author observed about forty occasions where the two nurses prescribed a combination of analgesics (Panadol or Action) and antibiotics (Amoxicillin, or Ampicillin) for all presented stomachaches. Of the one hundred children who made specific requests for pharmaceuticals, each demand for medicines for stomachache was followed by an inquiry into whether it was due to diarrhoea, to painful monthly periods for girls, or whether it was just pain in the lower abdomen.

Another source of data was the children's exercise books which they presented in the state-aided centres for a written diagnosis. In one exercise book, a fourteen year old girl, girl, who presented with stomachache at Gulu Regional Referral Hospital (GRRH) was given the diagnosis of a urinary tract infection. Subsequently, Amoxicillin and Indocid had been prescribed, which she bought in a drug shop and used. Nevertheless, she experienced the same stomachache two weeks later. This is her explanation about the persistence of her stomach ache:
In a workshop, two adolescent girls, who often complained about having stomach aches, presented atika plants as the medicine which they were advised to use for such persistent pain. They both told about their nightmares where violent men wanted to rape them in their sleep. It is therefore plausible to assume that the girls used the idiom of stomach ache to represent episodes of rape. For example, the thirteen year old girl gave this account:

“For a year now I have been having bad sleep. The moment I enter the hut at night, even before I sleep, I see a very huge man who wants to attack me. Sometimes he comes with a knife. The moment I fall asleep, that same man comes to rape me. In such moments I scream and wake up. When I told our landlady about it, she advised me to put branches of atika plant at the doorpost and window, to smear its seeds over my head and around the mat. When I am going to sleep, I should burn some atika plants in a partially broken pot."

During home visits and inquiries about income generating activities, this girl disclosed how she had previously cleaned and smeared neighbours’ huts with cow dung to make them neater. However, one time she was attacked by the man who had asked her to clean his hut, so she subsequently avoided carrying out such activities.

One former child soldier disclosed the following about her neighbour who had persistent stomach aches:

“My neighbour has been having stomachaches ever since she was attacked and raped by five boys on her way to a shelter. The night she was attacked, she left home alone to the shelter after 8 pm. When she reached the shelter, she did not tell anyone. She simply went to sleep. But since that day, she has taken all kinds of medicines but has not recovered. She often visited at yat adit (GRRH) and much as she has been given many medicines, she still has stomachaches."

Cwinya cwer (sadness) and can dwong ataa (deep emotional pain)
The phrases cwinya cwer (bleeding hearts) and can dwong ataa (deep emotional pain) were mentioned by forty children in various focus group discussions. Bleeding hearts is interpreted as sadness. A twelve year old boy concluded how, following the LRA abduction of his brother and the killing of his father, “with such cwinya cwer, even when they give you everything, you cannot enjoy this life”.

The boy discussed how he felt cwinya cwer and can dwong ataa when his sister-in-law had burnt down their hut and all of their belongings, and when he witnessed the killing of his father by the LRA when he was about twelve years old in this way:

“We were going to dig outside the camp when we met latin lum moo (certain child soldiers). They ordered us to drop the hoes and kneel on the road. My father started arguing with the LRA that we needed to go and dig and not to start playing. That is how one of the soldiers shot him in his head. At that moment I felt a lot of emotional pain; I felt deep emotional pain when the child soldier shot and killed my father.”

In the same narrative, he also shared his experience with lack of sleep and persistent nightmares because of the tipo of his late father, who demanded that he perform a guru lyel ceremony that is the last funeral rites.

“I am constantly disturbed in my sleep by my late father’s tipo who demands that I give him money for alcohol and organise the ceremony of guru lyel. I told my mother about it, but she advised me to smear atika plant all over me and put its branches at the doorpost and also where I am going to sleep. Meanwhile she is still selling alcohol so that she will save enough money for the ceremony."

Two children depicted the burning of their younger siblings, who were still asleep in the huts, whom they were unable to rescue. Twelve year old girl was quite emotional during her discussion, and she evoked frequently and interchangeably the phrases cwinya cwer and can dwong ataa in reference to the accident of a hut fire in Pabbo camp.

“It was a Saturday … I still remember clearly. During that ywoyo (end of school term holidays) I went to live with my aunt at Pabbo camp. This story always makes me feel cwery cwer and can dwong ataa. My aunt always left me in the camp with my two year old cousin so that I could take care of him and make sure that nothing bad happened to him...I always did as she said, and on that day I had fed him and put him to sleep. I was at the neighbour’s place when people began shouting ‘fire, fire!’ Everyone was running away from the camp. The fire was already burning huts in the zone where my aunt’s hut was. I tried to run towards it and see if I could get my cousin out’’
[here she wept bitterly as everyone watched speechless].
She blamed herself for putting her cousin to sleep in that hut, and for her inability to run fast enough to rescue him.

**Quests for therapy for cwer cwiny and can dwong ataa**
The first author posed a question to various children, asking about what specific methods and interventions were effective in dealing with such suffering as cwer cwiny and can dwong ataa.

This is what girls said during an interview:
“Sickness involving disturbances by tipo/ cen cannot be dealt with in the hospitals. People instead use atika plants, and some go for prayers with morokole (saved people). For me, all these things did not work until we went to see an ajwaka at Karuma.”

In eight different focus group discussions with children aged twelve to fifteen years, one fourteen year old girl concluded, after a long discussion about the use of atika plants and other pharmaceuticals for can dwong ataa and cwer cwiny:
“I have been using atika plants for years now. First I was using them because when my elder brother was abducted by Kony I could not sleep. Later, when that stopped, and I was living in Gulu town, I again started having nightmares of huge men who wanted to rape me. Although I use atika plants, I still have those dreams. Maybe can en cango kene (this suffering heals itself).”

At the mention of can en cango kene, the other nine children present reacted by narrating their own experiences with can or can dwong ataa, and all agreed that misery and deep intensive suffering should perhaps heal itself.

**DISCUSSION**

**Chronicity of psychological distress**
The empirical data suggests a high prevalence of complaints symptomatic of psychological distress presented in somatic idioms. These somatic complaints were minimised with pharmaceuticals including analgesics, antibiotics, medicines with and psychopharmaceutical properties – and herbal remedies such as atika plants. Children also attended deliverance and healing services in attempts to minimise their suffering and deal with persistent nightmares, body aches, and disturbances by cen and tipo. Nonetheless, despite all these therapeutic quests, their symptoms generally persisted. Neither traditional or biomedical medications, nor prayers or the laying on of hands apparently sufficed to effectively respond to this type of suffering. One could think of different reasons for why such symptoms resisted the various forms of therapy. A symptom based management approach to emotional pain neglects the complex causality underlying such suffering. For instance, a wide range of pharmaceuticals was advertised as effective remedies for headaches at the time of the study. If the headache and other body aches of a child are due to factors such as living in poverty or mourning brutally murdered kin, a mere focus on the headache will not provide any real solutions. Given children’s helplessness in the face of the underlying problems, children’s opting for short term curative solutions seems only rational. Their strategies, however, are not only ineffective, but also lead to chronic disease conditions, unnecessary suffering, development of resistance of micro-organisms to antibiotics and the over-use and abuse of medicines.

Further, another factor could be the element of desperation associated with the emotional or psychological pain against the background of inadequate medical resources and trained human resources in a situation of armed conflict. The optimal relief of symptoms, whether somatic or psychological, requires an accurate diagnosis of a clinical problem by a competently trained health care professional who in addition has the skills necessary achieve the desired clinical outcome.

In northern Uganda, little was done to address children’s structural poverty. Thus far no efforts had been undertaken by the state to compensate children, their families and indeed their communities for how they had been wronged. Humanitarian agencies did help to alleviate suffering within the mandate allowed to them by the state – for example through ensuring children’s psychosocial well-being. That help, however, was in most cases irrelevant to the emotional and psychological needs of most traumatized children and problems of psychological nature were labelled as trauma. The NGOs’ primary approach to counter such problems was that of counselling and creative activities, such as plays, traditional dances, promoting compositions, and singing peaceful songs.

Currently most researchers recommend taking a comprehensive or holistic approach (as suggested by Bracken 1998; Summerfield 1998; Richters 1998; Giller 1998; Weiss 2000; Bala 2005) in interventions for people in wartime, listening to local priorities, strengthening the family and community structures on which children depend for their security and development and rebuilding informal networks for mutual support. This study has added substantially to the lively debate on such issues by investigating – from children’s perspectives – their priorities regarding...
Two conclusions may be drawn from this. Firstly, in the context of civil war in northern Uganda, and in the light of children’s dominant expression of psychological distress in physical symptoms, healthcare providers should take caution when formulating diagnostic problems. The client might need antibiotics, antimalarials, or medicine for indigestion, but attention must be paid to the possible likelihood of an underlying presentation of psychological distress. But if it is accurately diagnosed that a child presenting with headaches, stomach aches, and the sensation of something painful moving around the body is suffering from psychological distress, appropriate intervention based on a holistic approach is required.

The second conclusion from this study is that the only sound way to effectively manage children’s complaints symptomatic of psychological distress, is to address the underlying structural inequity that they suffer from, to acknowledge how they have been wronged and find ways to compensate them and help them to mourn. But given the breakdown of the legal and social systems at the time of this study it is difficult to suggest what is appropriate for this context. Nevertheless this study highlights the need for healthcare providers and humanitarian agencies to respond more appropriately in similar circumstances in the future by asking questions like: Is it through counselling? Is it in leaving the can to cango kene (suffering to heal itself)? Children must feel assured that other people recognise and acknowledge their suffering, but they must also be allowed to gradually come to terms with the severe events themselves, and thereby experience psychological healing. It is painful to conclude that addressing the core causal factors of complaints symptomatic of psychological distress is beyond children’s abilities in the study context, and moreover, that they recognised this.

The need for a comprehensive approach
There are indications that children linked particular somatic complaints to psychological distress. Where children presented with somatic complaints, an etic in-depth analysis suggested an interpretation of the symptoms as expressions of psychological distress. Subsequently, there are symptoms including persistent headaches, cen, and something painful moving around the body which have been described as complaints symptomatic of psychological distress resulting from underlying social problems. These latter problems include, but are not limited to, living in strained family relationships, acts of violence committed by former child soldiers while in captivity, and gender based violence. Children described emotions such as anger and bitterness, and feelings of guilt and misery as well as disturbing memories that resulted from these social problems.
Beyond children’s curative ways of dealing with psychological distress is the presence of professional healthcare givers and religious healers, and their approaches to promoting psychosocial wellbeing. Their perspectives on how best to deal with distress encompassed biomedical perspectives, psychiatric, psychological, and religious healers’ viewpoints.

During regular visits to the psychiatric unit, no traumatised clients (adults as well as children) were observed seeking professional help there, regardless of the radio talk shows, sensitisation seminars, and announcements calling for people who had witnessed or experienced traumatic events to seek specialised help from this unit. Was this because Acholi people think psychiatric units are only for ‘mad’ people? Was it because Acholi people – including children – know indigenous ways of dealing with such suffering? Or was it because the unit itself has a history of only providing short term solutions and temporary relief from symptoms? In what better ways can the new psychiatric unit address the ‘hidden epidemic’ of trauma?

Even in the psychiatric approach there is a danger of medicalizing highly complex problems – which have their root causes in the socioeconomic and political realm. Whereas antidepressants are widely known for providing symptom relief, their efficacy in addressing children’s core issues is questionable. We do not intend to imply that the regional hospital’s psychiatric unit is not in any way beneficial for the community it is supposed to serve: a community that has experienced prolonged civil war. In fact, at the time of this study, many clients – mainly sufferers of epilepsy and psychiatric disorders such as psychosis, from Gulu, Kitgum, Pader, Amuru and Southern Sudan – received free medical attention from this unit. In 2007, it was sometimes difficult to find an empty bed due to the presence of many people admitted for close monitoring. Nonetheless it is striking that whereas a ‘hidden epidemic’ of trauma was acknowledged, no children with related symptoms were approaching the psychiatric unit for help.

As the results suggest, children frequently named religious healers as instrumental in conducting healing services for people with various forms of psychological problems. The approach was to deal with the evil spirits and teach people to take charge of their own condition by chasing away Satan themselves. During healing services there was a major focus on Satan, and ordering him to stop disturbing God’s children. If such approaches are useful, and are consistent with indigenous ways of dealing with distress, they are commendable. Nevertheless, such approaches can pose problems. If the child identifies that it is

the cen of a close kin member that needs appeasement, then perhaps ordering every cen to leave the ‘children of God’ is in fundamental conflict with the child’s ready identification with the cen as recently departed kin. This study proposes that if children are suffering through the experience of cen due to the recent loss of close kin, they need to be made aware of the link between their recent loss and the expression of their symptoms and feelings of loss. In the process, it must be acknowledged that there are certain realities, and forms of emotional suffering, which such children must come to terms with. Children may then be made aware that with time – no specific period of time since this depends on how the individual client was affected – they may experience less and less of such symptoms.

Noticeably, however, we have attempted to clarify what could constitute a holistic approach to the alleviation of psychological distress in northern Uganda, including counselling, religious approaches, material support, and even simply recognising the complexity of suffering. We use here the term minimising as opposed to finding a therapy for psychological distress, based on the belief that it is likely that such suffering cannot be dealt with in a one-time intervention. Further, viewing the overcoming of psychological difficulties as a process might help in limiting the prescription of short term solutions to complex forms of suffering. We suggest that major attempts must thereby be made to promote psychological wellbeing taking into account people’s own perspectives, needs, and priorities.

REFERENCES

1. Accorsi S; Fabiani M; Nattabi B; Corrado B; Iriso R; Ayella EO; Pido B; Onek P.A Ogwan M; and Declich, S (2005) The disease profile of poverty: morbidity and mortality in northern Uganda in the context of war, population displacement and HIV/AIDS.
2. Transactions of the Royal Society of Tropical Medicine and Hygiene 99 (3) 226-233.
CULTURE AND TRADITIONAL HEALING IN CONFLICT/POST-CONFLICT SOCIETIES

Seggane Musisi1*, Elialilia S. Okello1 and Catherine Abbo1.
1Dept of Psychiatry, Makerere University College Of Health Sciences

Abstract
Cultures have evolved as complex human activities passed on over generations to maintain peace, preserve and protect a united community and ensure its propagation. Conflict often arises in the overzealous attempts to achieve the above, to exploit resources even from neighbours for the greedy use of one’s own community or for ideological hegemony. Such conflicts often result in wars causing much suffering and misery to affected individuals and their communities. In today’s globalised world where there is the use of modern weapons the damage of such mass trauma is horrendous, yet the reparatory resources are limited, leaving many a traumatised people on their own to heal and rebuild their lives. Traditional healing systems have often been called upon by the affected communities. However, little has been written about them, especially in Africa. This paper attempts to explore ways of how best to incorporate and utilise traditional healing systems for mental health care in the complex health emergencies arising out of war conflict.

Introduction
Culture comprises of all those complex human activities and experiences which are encoded and communicated symbolically in society and passed on from generation to generation. The purpose of culture is to maintain peace, preserve and protect a united community and ensure its propagation for generations to come. Mass trauma, as happens in war-conflict, causes violent disruption of this peaceful co-existence with consequent deleterious effects on individuals, families and communities and retards development. It destroys the bonds that bind individuals to each other, to their community and one community to another.

Healing is the process by which the disrupted equilibrium in an individual, family or community/nation can be brought back to harmonious peaceful co-existence physically, psychologically, socially and spiritually. On the other hand, reconciliation is the process whereby conflicted/warring/aggrieved parties agree to resolve their differences and animosities towards each other, come to a mutual understanding to co-exist in peace; to forgive, to abandon the fighting and move on. It does not mean forgetting the past.

Today, over 60 countries in the world are affected by conflict/post-conflict health problems (1). Most of these are in developing countries (2). There is overwhelming evidence showing that mass trauma in conflict/postconflict societies is associated with considerable mental health problems (2).

*Correspondence:
Prof. Seggane Musisi
Makerere University College of Health Sciences
P.O. Box 7072 Kampala
E-mail: segganemusisi@yahoo.ca

Furthermore, literature shows that over three quarters of the world’s population is emotionally and culturally tied to indigenous systems of health care and this also includes the care for the mentally ill (3). In Africa and Asia alone, over 80% of the mentally ill at some point seek treatment from traditional healers (3). Indeed traditional healing exists side by side with Western medicine in these countries. In the Western countries themselves alternative medicine has become increasingly popular in the last twenty years (3). It is also well established that societal beliefs (culture), attitudes and responses influence people’s ideas about mental illness and their subsequent health seeking behaviour. In most developing countries the Psychiatrist to patient ratio is 1:1,000,000 or more and yet the Traditional Healer to patient ratio is 1:50,000 or less (3). Thus in terms of accessibility, traditional healers are far more prevalent and accessible to the population than (Western) trained medical doctors. Even when one considers all mental health professionals put together (psychiatrists, psychologists, nurses, social workers, occupational therapists, counsellors etc), still traditional healers are the main source of care in 80% of cases either by people’s choice, preference, or by their sheer availability and accessibility (3).

Communities, through the years, have built cultural systems to maintain their integrity, unity, peace, and to preserve, protect, heal and propagate themselves and reconcile with neighbouring communities. The collective totality of all that knowledge is what may be called the community’s heritage or traditions, or ways of doing things e.g UBUNTU in Africa. Communities, thus use these cultural systems to maintain internal peace, defend against external interference, increase productivity, make peace/reconcile with neighbours and establish a system of healing to restore health, harmony, peace and life to the ill-affected.
This is what can be considered as traditional healing after conflict.

Traditional Healing has been defined as “the sum total of all knowledge and practices, whether rational or not used in the diagnosis, prevention and elimination of physical, mental or social imbalance, and relies mostly on practical experience, observations or knowledge handed down from generation to generation verbally, by apprenticeship or in writing” (4). In conflict/post-conflict societies, the mentally affected people are part and parcel of their massively traumatised community together with their traditional healers who live amongst them and with whom they share their same environment, beliefs, fears, hopes, faiths, culture and any available resources including their destiny. In a Primary Health Care approach, therefore, traditional healers must be part and parcel of the integrated approach to mental health care delivery in a very cost-effective and efficient manner.

A Traditional Healer is a recognised and respected member of the community who effects healing through the use of plant, animal or mineral product or any other means (whether proven or not) by knowledge passed over through generations. He/she lives in the community in which he/she practices, identifies with the community, eats the same foods, speaks same language and has experienced the same trauma. He/she is able to recognise signs and symptoms of illness disequilibrium in that cultural community and has the same explanatory model of illness causation. Over 75% of the world’s population (especially in Africa and Asia) is emotionally and culturally attached to indigenous systems of health-care, including mental health care. Studies in Africa (13), Asia (6, 7) and Latin America (2) all demonstrated that most victims of mass trauma go to Traditional Healers for care.

This paper will examine ways of how best to incorporate and utilise traditional healing systems for mental health care in the complex health emergencies of conflict/post-conflict societies and to identify research areas that need to be addressed.

**Scientific evidence for Traditional Healing in Complex health emergencies**

Studies done in Africa, Asia and among Native American Indians (in both South and North America) have repeatedly shown Traditional Healing to be effective in treating many common forms of mental illness (2,3,4). Kleiman and Sung (1979) investigated Chinese Traditional Healing practices in Taiwan by local Shamans (Tang-Ki) and concluded that most patients (90%) presented with ‘chronic-self limited illnesses and masked minor psychological disorders with 50% of the latter presenting as somatisations (5). Most reported improvement after the Tang-Ki treatment.

The major determinants of the outcome were:

i. Quality of therapist-client communication (language and attitude).

ii. Belief in, compliance to and satisfaction with the treatment (explanatory model).

iii. Care of the clients in their own community, culture and language.

They concluded that for healing to occur, medical care cannot be in the abstract but must be anchored in a particular social and cultural context. This provides for the balance between “control of sickness and provision of meaning to the experience of illness.” These universal therapeutic components of psychotherapy have been noted to be present and recognisably effective in both traditional and modern treatments thus favouring the argument that indigenous forms of psychotherapy treat certain psychological and physiological diseases (5). Today’s evidence of the psychic ameliorative effects of Meditation, Yoga, Biofeedback, Relaxation therapy, Exercise and a wide variety of behaviour therapies on psychological dysfunction all favour a rendering of meaning to care as a most important aspect of wellbeing. Traditional forms of practice lead to ‘healing’ and do not just limit themselves to ‘cure’ of illness. This adds ‘human value, cultural balance, peace and meaning to life and existence’ in the care of patients. These factors are central to affecting mental health healing and stability to the massively traumatised individuals as found in the complex humanitarian emergencies of conflict/post-conflict societies.

Various studies in Thailand and Cambodia have attested to the need and use of Traditional Healing systems in dealing with the mental problems of massively wartraumatised populations (5,6,7). Van De Put and Eisenbruch (2000) studied Cambodian warsurvivors of the Khmer Rouge ‘killing fields’ (6) and concluded thus: “Traditional beliefs and traditional healers of many kinds were essential in offering people at least a thread of continuous identity in the massive turmoil that threatened their existence and culture”(6). They felt that any intervention aimed at alleviating the psychological suffering of the wartraumatised peoples needed to be complimentary to or at an absolute minimum be informed about the work of the Traditional healers. Mollica et al (1994) came to the same conclusions (7).
In Africa, Musisi et al (2000) also found that many war-traumatised individuals resorted to traditional faith healing practices to deal with their massive psychological problems (13). Workers in Latin America described the beneficial role of traditional healers including the ‘Curanderos’ in helping the massively traumatised local Indigenous Indian populations e.g. during the plantation conflict and hurricane displacements (2).

The questions which are often asked are:

i. Why do people prefer Traditional Healing even when modern care is available?
ii. Do Traditional Healing Systems really work and if they do, how?
iii. How could Traditional Healing Systems be used in the complex humanitarian emergencies of conflict/post-conflict societies?

In dealing with the above complex questions, some workers have questioned the validity of universalising Western concepts of suffering to other cultures. Bracken (2001) argued that Post-Traumatic Stress Disorder (PTSD) is a peculiar construct of life in contemporary post-modern societies of the West and denied its universal application to other nonwestern cultures (8). On the other hand various workers have described a core set of symptoms found in all cultures and societies as constituting the core syndrome of PTSD as described in the American Diagnostic and Statistical Manual of Mental Disorders, DSM- IV (9). Moreover numerous historical reviews have always referred PTSD but by various names e.g. Shell shock, Soldiers heart etc. O’Brien (1998) has claimed that “PTSD is merely the renaming or synthesis of an age old condition.” Whatever the arguments, all agree on the varied expression of psychological distress in different cultural settings thus giving rise to the notion of ‘Post-traumatic culture-bound syndromes’ (10). The central themes in all these various cultural healing systems in the face of mass trauma was:

i. respect for human life.
ii. recognition of what constitutes a good and meaningful life.
iii. the notion of personal dignity.

Mass trauma denigrates all the above three concepts. Yet for any healing to take place in conflict/post-conflict communities, one must pay respect to the specific cultural meanings of those three notions hence the importance and centrality of Traditional Healing Systems in war trauma.

It is through cultural traditions that man values human life; constructs the meaning of life and respects personal and others’ dignity. In Africa, this is embodied in the now universalised concept of Ubuntu or “humaneness”.

Harmonising science and cultural experiences in traumatised individuals

There has been considerable work geared to harmonising the vast scientific evidence pointing to the universal physiologic processes seen in trauma victims and yet presenting with differing idiomatic expressions of distress specific to particular cultures as the so called ‘Post-Traumatic Culture-Bound Syndromes’ (10). This often causes confusion when the affected victims migrate out of their homelands to especially Western industrialised societies e.g. the ‘Ataques de nervios’ of Latin Americans in USA and Canada (2). Boehnlein (2001) describes the ‘cultural interpretations of physiologic processes in PTSD and panic disorders’ (11). He argues that “listening simultaneously to the literal (spoken) language, knowing cultural metaphors and observing somatic (body) language leads to a more comprehensive understanding of human suffering in the psychiatric care of the traumatised. Thus ethnographic observations, consultation with traditional healers when integrated with modern clinical skills produced a better understanding and care of the traumatised patients. Thus in Cambodia, ‘Kyol goeu’ or ‘wind illness’ becomes a prototype PTSD in traumatised victims. In Africa, Van Duyl (12) and Musisi et al (13) observed various somatoform disorders, dissociation, hysteria and possession states in traumatised IDP (Internally Displaced Peoples’) camp refugees in Uganda in what would otherwise be classic PTSD syndromes. This cultural link between a prototypical illness which is variously expressed and the physiologic experience which is universal argues well for a better understanding of PTSD in the massively traumatised in different cultural settings and points to a need to develop culturally competent approaches to treatment of victims of complex humanitarian emergencies in different cultural settings. Such understanding calls for the inclusion of Traditional Healing alongside Western medicine when dealing with traumatised populations especially where issues of social, cultural, religious and family variables are concerned. Thus in summary, culture influences not only the patient him/herself, but also the patient’s family, social environment and his/her intimate sensations and interpretations of physical bodily functions and experiences during times of great psychological distress as is commonly seen in the massively traumatised. This also applies to the experience of the effects of drugs and their side effects.

Traditional Healers working methods

WHO has characterised Traditional Medicine as “ those diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and /or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly.”
or in combination to maintain the well-being of the patient as well as to diagnose, treat or prevent illness" (3). Traditional Healers, therefore, use all kinds of techniques to effect healing. Abbo (2003) in Uganda classified these into four categories:

(i). Phytotherapy and other medicaments (Herbal/plant, organic-animal and non-organic remedies: taken orally, smoked, inhaled or applied topically).

(ii). Talking therapies (Psychotherapies and Counselling)

(iii). Behavioural modification therapies (symbolisms, rituals, drama, song, drum and dance, and interactive group therapies).

(iv). Spiritual (Faith) healing including spirit consultations, divinations, prayer and possession states and/or carrying/wearing protective artefacts.

In conflict/post-conflict communities Traditional Healers have been found useful in the following instances:

i. To mobilise the people into or for particular actions.

ii. To provide meaning to the experiences of traumatised victims e.g. Dissociation and Possession states in Africa or Ataques de nervios in Latin America, or Kyul-goeu in Cambodia etc.

iii. To treat common psychological discomforts e.g. anxiety, panic, depression or demoralisation.

iv. Case identification, management and referral of more complex cases.

v. To resolve interpersonal conflicts especially in traumatised families.

vi. To instil values, norms and morality where these have been destroyed by the traumatic social disintegration of war or conflict e.g. destroyed neighbourhoods, wayward teenagers in IDP camps, rampant sexual abuse of women in war-torn areas etc.

vii. To restore a sense of identity and cultural continuity where these have been broken by conflict e.g. broken families, orphaned children, the widowed etc.

viii. To create a sense of hope and faith as is in spiritual (Faith) healing in seemingly hopeless situations.

ix. To restore dignity to the wronged, pay respect to the dead, implore justice for all and cleanse desecrations.

x. To enhance tolerance, understanding and patience and to avoid the vicious cycles of trans-generational traumatisations and hatreds. For example, traditional rulers using Traditional Healers have waged or stopped waging wars in so called culturally justified wars e.g. the Mau Mau and Maji-Maji armed rebellions in East Africa against colonisers.

Methods of incorporating traditional healing systems in the mental health care of conflict/post-conflict communities

Up-to now there is no universally agreed upon method of incorporating Traditional Healing systems in complex humanitarian emergencies although their importance is universally acknowledged (16). This is an area in need of much systematic scientific research. Nevertheless, the following principles need to be observed:

i. The cultures and beliefs of the traumatised peoples must be respected.

ii. Existing knowledge of healing must be acknowledged, respected and incorporated as appropriate.

iii. Universal respect to human life, values and dignity must be observed.

iv. There must be adherence to the principle of universal human rights and respect for all irrespective of gender, race, ethnicity or religion.

v. Practices that are traditionally discriminative must be discouraged e.g. class, caste, racial, gender, tribal or religious prejudices.

vi. The medical, social, security, food, housing and spiritual needs of the traumatised community must be catered for in a culturally accepted way.

vii. Traditional Healing systems need to be incorporated early and at Primary Health Care level alongside other treatments and with no associated stigmatising labels.

In order to successfully incorporate traditional healing systems in the complex humanitarian emergencies of conflict/post-conflict communities, surveys to establish and address the following need to be done:

i. The cultural practices and beliefs of the affected society.

ii. The nature and magnitude of the problems involved.

iii. The traditional knowledge and mechanisms of dealing with problems.

iv. Available resources: money, personnel, knowledge, expertise and materials.

v. The useful and beneficial traditional practices to be incorporated.

vi. The possible harmful practices to be modified or discouraged.

vii. Innocent/neutral practices to be left done.

viii. Identification of culturally competent clinical practitioners to work with the traditional healers.

ix. The role of traditional governance or rulers (chiefs) in peace making.

x. The role of Traditional Justice systems in conflict resolution. Examples of these have included Ga Cha Cha courts in Rwanda, Mat-o-put in...
Northern Uganda, Kitawuluzi traditional courts in Central Uganda (Buganda kingdom), Khadhi courts in Zanzibar etc.

xi. Spirituality and forgiveness. This needs to be explored. For example, in the post-apartheid era, in the spirit of Ubuntu, communities in South Africa have used the non-adversarial Truth and Reconciliation Commission (TRC), to heal and reconcile communities and create a spirit of hope and forgiveness.

xii. Cleansing, traditions and morality. Post-conflict communities are often faced with complex issues that need to be solved (14). For example, what to do with children born of mass rapes (17), how to rehabilitate child soldiers, what to do with surrendered perpetrators or those given amnesty. Cultural Traditional healing systems (18) will usually have ways of dealing with these as in the cleansing rituals seen in Northern Ugandan returned formerly adducted child soldiers.

As preventive measures for the seemingly non-ending vicious cycles of conflict in Africa, this paper will end with some questions as so often, peace seems to elude many an African country. These questions are:

1. Why do African countries, which disregard traditional cultural governance systems seem to have the worst forms of conflict and human rights violations?
2. Can imposed foreign solutions work for conflicted countries in Africa e.g Somalia?
3. Why do modern African leaders abhor traditional cultural leaders and elders? Have we lost something in our traditions which helps build peace?
4. How can our modern African states build governance cultures of tolerance, caring, respect and observance of universal human rights for all their peoples in their diversities?
5. Can Africa afford this “run away” fighting?

REFERENCES


OUTCOMES OF THE PSYCHOSOCIAL RESPONSE TO PERSONS AFFECTED BY THE KAMPALA BOMBINGS OF JULY 11TH. 2010

Christina Ntulo1**, Margaret Mugherera2 and Sheila Ndyanabangi3

1. BasicNeeds UK in Uganda, P.O. Box 29582 Kampala, Uganda.
2. Departmen Of Psychiatry, Mulago Hospital. P.O. Box 7051, Kampala. Uganda.
3. Co-ordinator Of Mental Health Services, Ministry Of Health, Kampala, Uganda.

Abstract
Mass violence is not new to Uganda. Since Uganda's independence, in 1962, it has consisted of political violence, warfare, mob vigilante violence and, in the recent past, urban terrorism. Despite this long history of mass violence and other natural disasters, no mechanism has ever been put in place to deal with its immediate psycho social fall out. On July 11th 2010, terrorist bomb blasts went off in two places in Kampala in the night as people watched the World Cup football finals. Panic ensued. The Ministry of Health and that of Disaster Preparedness were all caught unawares. Mulago Hospital Emergency Psychiatric Service together with BasicNeeds (UK) in Uganda organized psychological first aid to the acute victims of these bomb blasts, their families and those involved in the rescue mission. This paper presents a summary of the report of the evaluation of the outcomes of the immediate psychosocial interventions carried out to persons affected by the Kampala terrorist bombings of 7/11.

INTRODUCTION
Urban trauma, resulting in mass injuries of people, is not new to Uganda (1). It has consisted of politically inspired violence, such as the “panda gari” police operations (1), mob vigilante violence, political riots, election violence, frank war-fare (2) and, in the recent past, urban terrorism (3). In the past, not much has been done to care for the victims of this wanton violence. Almost twenty years ago, in his pioneer research article, Walugembe (1994) argued that despite years of warfare in Uganda, including wars in Kampala city itself, Post-traumatic Stress Disorder or PTSD was not being diagnosed in victims of this violence attending the Mental Health Clinic at Mulago hospital, Uganda’s main teaching and referral hospital (1). He challenged the clinicians then to look out for this diagnosis and care for the presenting patients appropriately. However, even up-to now, Uganda’s Ministry Of Health has no contingent plan to handle victims of mass violence. Literature elsewhere and within East Africa itself abounds on the psychological effects of mass violence. Njenga et al (2004) described the psychological fallout of the American embassy bombings in Nairobi, Kenya (4). Others have written about the crisis management of victims of post-election violence in Kenya (5). In other countries considerable literature abounds on the psycho-traumatic sequelae of urban and other forms mass trauma and organized violence (6). Musisi et al (2000, 2004, 2005) described various mental health problems of mass trauma in Africa, Uganda inclusive (11, 12, 13). This paper presents the report on the evaluation of the outcomes of the immediate psychosocial interventions carried out to persons affected by the Kampala terrorist bombings of July 11, 2010.

BACKGROUND
On July 11th. 2010, bomb blasts went off in two places in Kampala City, Uganda in the night as people were watching the final football matches of the World Cup causing injuries to masses of people (3). About 80 victims died. The City went into panic despite prior warnings by Uganda’s armed forces of possible attacks to Uganda after the Al-Shabaab terrorist group in Somalia had threatened to “bring the war to Uganda and Burundi” after these two countries had sent there peace keeping forces.

Uganda’s health care systems were caught totally unprepared for this mass trauma. Despite this, the victims were swiftly whisked off to Mulago Referral Hospital and the nearby Kampala International Hospital (IHK). Emergency resuscitation and treatment for the physical injuries was promptly started. However, there was no immediate psychological care in either of the hospitals and no psychiatric crisis teams were in place to be called upon in case of such mass trauma. The next day, BasicNeeds (UK) in Uganda, (BNUU), and the Psychiatric Emergency Service of Mulago hospital scrambled to put up the badly needed psychological support team to render “psychological first aid” to the acute victims of these bomb blasts and their families.

*All correspondence to
C. Ntulo, BasicNeeds UK in Uganda
P.O. Box 29582 Kampala, Uganda.
Telephone +256 414 269558.
Email: info.uganda@basicneeds.org
A psychosocial intervention team was set up composed of medical doctors, clinical psychologists, psychiatrists, counselors and social workers from Mulago National Referral Hospital, the Department of Psychiatry of the School of Medicine, Uganda Counseling Association, Uganda Red Cross, AAR, International Hospital, Kampala (IHK) and counselors from BNUU. Five months later, (Dec. 10th, 2010), a meeting was called to reflect on the outcomes of the provision of psychosocial and mental health response to these events. The deliberations in that “reflections” workshop form the basis of this report.

**Definition for psychological first aid.**
It was soon recognized that whatever psychological help that was given to the victims was “psychological first aid”. The team’s first task was to reach consensus on the definition of the term ‘psychological first aid’ as a concept often used by crisis teams in situations of acute trauma. Members agreed on the working definition of “Psychological First Aid” as: “Psychological first aid is the immediate support to a victim of trauma in order to forestall or prevent the development of further mental health complications. It involves helping people to understand the traumatic event that happened, rescue them, stabilize them and then help them move on to the next stage”.

**Getting organized.**
All members recognized the need to approach such an intervention in an organized manner. On reflecting on the first activities that took place within their organizations immediately after receiving news of the bomb blasts, the general consensus was that there were gaps in what actually took place immediately after the blasts had occurred. They felt this was due to lack of protocols on how an intervention like this should be organized. What was evident, though, was that many people were very willing to help and wanted to help but had no guidance.

Mulago hospital which has a consultative psychiatric clinical service and the Psychiatric Emergency service got into action first. They went around the hospital recording all patients getting emergency medical treatment, reassured them and noted their psychiatric needs. The scene was very chaotic and disorganized with the doctors and police working while at the same time managing the crowd at the Accident and Emergency Department and the overcrowded wards, they were enjoined by staff from Uganda Counseling Association (UCA) to provide counseling services to people at the Mulago Hospital mortuary who had lost relatives. However, due to the disorganization and lack of a working space there, the UCA counselors could not do much. There was no organized action plan from the very start.

BNUU and the Ministry of Health (MoH) co-coordinator of Mental Health services on Tuesday and Friday of that week held two meetings to determine the detailed intervention that later took place. A general consensus by BNUU, Mulago Hospital Psychiatric staff, the MoH and UCA, agreed to map out an appropriate psychosocial intervention team and process. Four days were lost in the process of preparation and there was a general feeling of inadequacy at the time lost in responding promptly. However, one doctor from Butabika Mental Hospital felt that in his opinion, this was the “most organized of all psychological first aid interventions in the history of Uganda” and he commended those present for all they had done in helping the victims and their families.

**THE INTERVENTION.**
By Friday July 16th 2010, a multidisciplinary psychosocial intervention team was set up, trained and the intervention procedures agreed upon. It consisted of 35 therapists. The team targeted the following groups for provision of services:
- Survivors not admitted in hospital
- Survivors admitted in hospital
- Family members / relatives of the victims
- Mulago and IHK hospital staff providing treatment for the victims.
- The media directly involved in reporting on the victims
- Police involved in the rescue efforts (Kabalagala, CPS, Nakawa & ERU)
- Ethiopians and Eritreans in Kampala who were targeted for the attacks.
- The Somali community in Uganda, who became the focus of anger/hatred.
- Red Cross staff who were involved in the rescue effort.

**Procedures**

*Intervention Sites:* It was decided to offer the psychosocial services at BasicNeeds premises, St Francis Hospital at Nsambya, and Mulago Hospital - Bossa Mental Health Unit, the ICU, wards and the Accident and Emergency Department. Other agreed upon sites included the New Vision newspaper offices (for the media staff), AAR, IHK (staff and in patients), Butabika Hospital Psycho-trauma Unit and at the ERU for the police.

The Intervention Team: A team of 35 counselors were mobilized to these sites to provided services. The team consisted of psychiatrists, medical doctors, clinical psychologists, nurses, counselors and social workers.

The Intervention Funds: Funds were collected by BasicNeeds. These included money donated from New Vision and UNNGOF at Ushs.
1,000,000/= each respectively. BasicNeeds raised an additional Ushs 1,000,000/= from the UK. An allowance of Ushs 10,000/= per therapist a day was provided. In addition to the daily allowance, fuel was provided to some supervisors. (1 US$ = Ushs 2000/=).

THE PSYCHOSOCIAL INTERVENTION
The psycho trauma
When traumatic events like mass violence and destruction take place, as happened with the Kampala Al-Shabaab bombings, those directly affected and those who provide them services both get traumatized emotionally and may even develop mental problems. Common reactions to such traumatic events include disbelief, emotional shock, grief, anger, broken hearts, loss of appetite, panic, exhaustion, fear, suspicion, flashbacks and nightmares (9). All these constitute the syndrome of Acute Stress Disorder (ASD) which, if not treated, goes on to become Post traumatic Stress Disorder, PTSD (DSM IV-R, 2000). With psychological first aid immediately after the traumatic event, the majority of those affected by ASD are able to develop coping skills and eventually recover. In addition, service providers need support to deal with the secondary trauma (vicarious traumatisation) so that the quality of their work is not compromised now or in the future. The following will describe the activities that were carried out at the respective sites after the bomb blast victims in Kampala, Uganda.

A total of 249 clients were given immediate psychosocial intervention at the various sites as shown in Table 1:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mulago Hospital</td>
<td>43</td>
</tr>
<tr>
<td>Police (ERU)</td>
<td>38</td>
</tr>
<tr>
<td>New Vision</td>
<td>77</td>
</tr>
<tr>
<td>Nsambya Hospital</td>
<td>15</td>
</tr>
<tr>
<td>African Air Rescue (AAR)</td>
<td>2</td>
</tr>
<tr>
<td>International Hospital Kampala</td>
<td>75</td>
</tr>
<tr>
<td>Home Visit</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>249</strong></td>
</tr>
</tbody>
</table>

Site I: St. Francis Hospital-Nsambya
Six counselors were attached to St Francis Hospital in Nsambya. They conducted 3 debriefing sessions to provide psychological first aid for caretakers, relatives of survivors and the injured. During the sessions, participants were encouraged to recount events of the night of 7/11 and share their feelings with the counselor and their caregivers. The purpose of the sessions was to help the clients to process their psycho-trauma and develop positive coping skills.

The team observed that all clients reported that the counseling sessions helped them cope. Some of the injured and especially those who were admitted were still in emotional shock and found it difficult to concentrate during the sessions. For such, the sessions were deferred to another day. Some clients reported feelings of guilt and blamed themselves for the incident. Others reported that they avoided watching news or reading newspapers about the traumatic events. Many avoided busy places like markets and churches. Some clients were very emotional and found it difficult to talk, however they were happy about the space provided for them to let out their emotions.

The following will describe the activities that were carried out at the respective sites after the bomb blast victims in Kampala, Uganda.

Site II: New Vision Newspaper (Uganda)
New Vision Printing and publishing Company was participating in the events to celebrate the World Cup Finals at Rugby Club on July 11th 2010. Seven of their staff were on duty at the scene of the bomb blasts. One died. Others went after the blasts to cover the events. Many were badly emotionally affected by the traumatic events they saw or witnessed. One media reporter initially said:

"In the beginning since that night when I survived the bomb blast at Rugby Club. I avoided going to bed too early because I kept on getting night mares. I stayed out of bed up to 1:00 a.m. so that I could only have few hours of sleep. I looked at Somalis with another lens".

"Thank you so much for listening to me. I feel this has diffused the stress I was feeling. I now know the importance of counseling after this incident. I now know that what I was going through is normal. You have given me useful information. I am ready to cope with life. I believe I will sleep well."

African Journal of Traumatic Stress Vol 1 No.2 December 2010
Two counselors worked with the affected media staff from the New Vision Newspaper. The staff were 20 General Staff, 10 from Broadcasting 35 from Editorial and 12 from production. They received debriefing sessions and individual counseling. This included psychosocial education about stress following traumatic events, adjustment, the post traumatic stress response and recognizing symptoms as well as the common behavioral, emotional and thought process following or on witnessing terrible traumatic events. They were also educated on how to develop skills for self stabilization like anxiety relieving exercises, sharing experiences, grief therapy and when to seek referral for professional help. Some staff stayed behind for the question and answer sessions as well as individual counseling. The staff of New Vision newspaper reported that the intervention services were timely and had helped them deal with some of the effects of their traumatic experience. However, some of the Media personnel experienced delayed trauma-related psychosocial distress e.g. later on in their work when they had to cover difficult stories that involved death, pain, suffering and those which posed danger to their lives. Below are some captions from their debriefing sessions that depict how the media staff were affected.

Comments of a media client after the sessions:
“I feel very relieved, because this session has enabled me to open up for the first time on what happened to me. You have made me feel that there are people out there who care about us. This debriefing has enabled all of us here to offload the traumatic scenes we were exposed to. I am glad that you considered having this session with our photo team which was all affected in one way or the other. With subsequent sessions like this, we feel that there is going to be improved performance in our team. We appreciate all the efforts you put in to ensure that our team benefits from your psychosocial treatments. We feel that they should be continuous because as photo editors we are constantly exposed to traumatic scenes”.

Comments from injured staff of New Vision newspaper.
“You have shown a lot of love even when you do not know me. It is a challenge to me that when I am able to walk again, I will dedicate some of my time to doing such work in hospitals. Every time I see you people I get encouraged that even if I am still in pain, people really care. Thank you also for breaking the grief news in a professional way to a patient who was disturbing us. She has accepted it and is now living normally. Thank you for checking on me continuously and it gives me hope that people wish us well. When I am better I will try to visit all of you to thank you in person for the love you have shown me. You have made me feel better”.

Site III: Mulago Hospital Intensive Care Unit (ICU)
A team of 13 counselors was deployed at this site. The team conducted 4 group sessions with patients and caretakers in addition to offering individual counseling to 43 persons (15 survivors and 28 caretakers). However, The team was unable to talk to 2 severely injured survivors in intensive care because of their condition. In general all the clients seen were happy with the psychosocial services they received. However, 7 ICU patients were transferred to the Bossa psychiatric ward for further care. One was a young girl whose family had refused to support her because she had gone to the Rugby Club without the consent of her parents. After family counseling, the father reconciled with his daughter. Three survivors could not remember what had happened at Rugby Club and were referred for more intensive psychiatric intervention. Two survivors were severely distressed, violent and had uncoordinated speech (psychotic). They were also referred to the psychiatric ward for further psychiatric care.

Site IV- Mulago Hospital Bossa Mental Health Unit
The team at the Bossa Mental Health Unit in Mulago hospital comprised of Psychiatric clinical officers (assistants) and doctors from Makerere University Departments of Psychiatry and Clinical Psychology. There were also psychiatric nurses, social workers, occupational therapists and various mental attendants and volunteer counselors. Psychosocial services were offered to 15 survivors and one counseling session was held for bereaved families. Eleven bereaved families participated in this session. Also 2 members from the team held two counseling sessions for 20 rugby players as a way of supporting them. The Mulago Hospital Mental Health Unit also houses the inpatient psychiatric ward which handled those survivors who were transferred from the Mulago ICU.

Site V: International Hospital Kampala (IHK)
The clients seen at this site were mainly survivors and caretakers of those victims affected by the bomb blasts at the Kabalagala Ethiopian Restaurant. Six counselors were deployed to this site and they were able to conduct 2 debriefing sessions for staff (1 for staff of the intensive care unit and 1 to all IHK staff) and 1 group therapy session for the survivors and their caretakers (total of 15 persons). Sixty members of staff attended the first session and 17 from the Intensive Care Unit attended the second session. The sessions tackled two questions:
1. What does trauma do to you as a member of the hospital treatment team?
2. How can you deal with it and cope with the situation?
A UCA representative led the staff into a sharing session to handle the questions. She emphasized that life had to continue despite the uncertainty caused by the traumatic event. Further discussion led to other trauma-related issues which included:

1. Feeling confused and overwhelmed as to what to do at the reception center because so many people wanted attention.
2. Being traumatized by the scenes of so much blood and fresh human flesh.
3. ICU staff felt helpless when they could do nothing for the dying.
4. Ambulance drivers were saddened because even after driving as fast as they could, still some patients died upon arrival at the hospital. This often brought feelings of guilt and self-blame.
5. Trainee nurses had patients dying in their hands for the first time.

As a result, the staff found themselves living in fear and self-doubt. Many became hyper-vigilant and sought refuge in spiritual teachings, prayer and avoided busy places. Others became particularly suspicious of Somali nationals. The counseling sessions helped them realize that their emotions were normal reactions to mass traumatic events. They learnt to develop better coping mechanisms. The staff commended the psychosocial intervention team. Their work and confidence improved tremendously on the subsequent days.

Site VI: African Air Rescue (AAR)

AAR provided space in one of its clinics at Ecobank on Parliament Avenue, in downtown Kampala for the Psychosocial intervention team. Two counselors were deployed at this site and they were able to offer individual counseling to two bomb blast survivors and 1 caretaker.

The team therapist observed that one of the clients (survivor) was living in fear, guilt and self-blame. This is because she was the one who had invited her 3 friends who had died in the bomb blasts while watching the final football match at Rugby Club. The caretaker was unable to afford hospital bills and requested to be connected to the government department that was carrying out compensation of bomb victims. She wanted to use the money to pay the medical bills.

Site VII: Police Emergence Response Unit

This is the police unit that handles emergencies in Kampala city and was immediately called to come to the rescue of the bomb blast victims. A psychosocial intervention session was organized for this Uganda Police Force Emergency Response Unit (ERU) to help them deal with any psycho-trauma issues that may have developed as part of their work on 7/11. Thirty-eight police officers from the Uganda Police Force ERU attended the counseling session held on July 20th, 2010. Three of these officers were on active duty on that day and were involved in carrying dead bodies and ferrying survivors. The session included sharing experiences, thoughts and feelings related to the bomb blasts. While talking and sharing their experiences, one of the officers had this to say:

"Since 7/11, I easily get scared. Sometimes I get thoughts that I am going to be the next target of a bomb blast. I am worried that the blood of the victims and dead persons whom I carried that night may have infected me with HIV. But I dare not share these worries with my wife. I am still traumatized after carrying bodies whose intestines were out. However, sharing what I went through on that day with you and my fellow colleagues has made me have some relief in my heart. I feel more relaxed now."

The counselors discussed ways of coping with trauma. These included:

- Talking about it with friends and family and having a supportive family.
- Eating well, as well as physical exercise such as jogging.
- Seeking professional support from trained counselors.
- Avoiding negative ways of coping like drinking alcohol.
- Avoiding overwork and taking out time for pleasure and relaxation.

Home Visits and Spiritual Healing

A health worker reported that a colleague was in need of support. She had lost a son to the bomb blasts. As a result, she had withdrawn from friends and family and was not eating. Two counselors from BasicNeeds (UK) in Uganda (BNUU) visited her on July 21st, 2010. At first, the grieving mother was not willing to talk but after a prayer she felt comforted and she started sharing her feelings. During her sharing, it was learnt that the late son was her first-born with whom she had a very close relationship. She recalled that in his graduation speech he had promised to pay her back by loving her very much. She said:

"On his graduation, the only words he said were that: mummy my only gift to you is to love you."

The counselors shared things that she could do to cope with the grief like joining social networks. For example, in her case, she was a member of Mothers Union. So they encouraged her to get back to that group and to read her bible and other motivational books. They also encouraged her to actively thank God for the times and good memories she had had with her son.
They also told her to frequently visit her grandson (son to the late son) since this would bring some comfort to her. She reported back to work after 21 days. She said:

“I did not have appetite of eating. Am glad you came and now we can share this juice. Since I heard of the news of my son’s death, I have not read my bible but today I believe I will be able to read it”

At the end of the session, the client felt relaxed. She even made juice which she shared with the visiting team. Family support is key in helping one cope. This client testified that her husband and daughter had greatly supported her emotionally. It was also important to know the client’s faith because in this case, it was praying with a client that led her to opening up. Spiritual healing is often helpful in trauma victims.

**Challenges and Recommendations**

1. **Methodology.** Being that it was a first time for a team of this kind to work together, there was a need to streamline and standardize the work methodology, data collection roles and responsibilities before the counseling services started.
2. **Logistics:** Lack of logistical support compromised follow up those clients discharged from hospital. There is need for continuous counseling, support and follow up to the clients.
3. **Privacy:** There was lack of privacy at some of the counseling sites e.g in the tent. This could have partly limited clients from opening up fully.
4. **Language barrier:** In some cases counselors could not speak Luganda (a common language spoken in central Uganda). Trained translators should be part of the intervention team.
5. **Counseling awareness:** There is need to create public awareness about the need of professional counseling after any traumatic experience. Also there is need for more education for employing staff to identify symptoms of PTSD and refer employees for care.
6. **Staff Performance:** For improved performance of the staff, psychosocial services should be provided either as part of peer support, line management or all health care.
7. **Trauma questionnaires:** There were difficulties in administering the trauma questionnaire to the clients as some counselors were not oriented to the instrument or the need to collect data.
8. **Media:** Many clients were not happy with the media. They felt that the media was making money out of the bomb blast incident especially when photos of survivors and victims are used as top pages of newspapers.
9. **Police:** Police clients requested counselors to set up a plan where ERU staff could be counseled regularly as their work made them more vulnerable to psycho-traumatic fall-outs. Members also agreed that Officers In-charge of the Unit should be able to identify officers that required professional help and refer them accordingly.
10. **Visitors:** Interruptions from visiting groups including some police investigators were resented by the victims and their families. There was also lack of social support to victims and their families especially those that were admitted on the wards.
11. **Home visits:** These should be included in future psychosocial support interventions. This because some members of the public tend to fear coming to health centers.
12. **Other partners:** There were others also willing to support psychosocial support activities. There is a need to centrally coordinate all the psychosocial interventions providers e.g AMREF, African Centre for Trauma Victims (ACTV) etc.

**MONITORING & EVALUATION OF THE PSYCHOSOCIAL INTERVENTION**

Three questions were used to evaluate level of success:-

1. What went well?
2. What did not go well?
3. What can we do better next time?

**What went well?**

The 7 days of active immediate psychosocial intervention made people realise the importance of counseling. Working together as a multidisciplinary team and with Mulago Psychiatric Unit made it easy to identify and refer patients that needed intensive psychiatric services. There was a good working relationship with all the sites and counselors. This made it easy for the counselors to interact with the staff at the various sites. The counselors built relationships with clients. There was good coordination of the activities by the BNUU team thus providing an entry point to various partners e.g. Uganda Counseling Association (UCA). Home visits and spiritual healing were seen to be important considerations for some clients in psycho-trauma work. Finally director of BNUU summarized the whole exercise as: “For long, counseling has been ignored in Uganda. We feel that BNUU facilitated the provision of the missing link”

**What did not go well?**

There were initial conflicts of roles e.g between psychiatric staff and counselors especially on the first day. Some sites took long to get organized e.g. AAR and Nsambya. Some caretakers were skeptical about counseling thinking that all counselors wanted was to get intelligence information. Often, clients and caretakers were overwhelmed by visiting teams.
These teams included the Red Cross, National Psychosocial team and outsiders (especially relatives and friends). The hospitals needed to find ways to control the human traffic so that patients could rest and recover. Due to lack of awareness, some people only associated counseling to HIV/AIDS. There were no identification name tags for the team therapists. This led to their being mistaken for other personnel.

What needs to be improved?
Counselors should to wear T-Shirts and have name tags for easy identification. There is need to come up with a clear structure which states the category of counselors that should conduct psychosocial intervention activities. There is need to involve all team leaders in the development of tools for documenting psychosocial trauma activities. It is important to avoid client dependence on therapists and the intervention teams. One therapist observed and liked the way clients responded and appreciated the counseling services. ‘Some of them even wanted to stay with us longer’

CONCLUSION : THE WAY FORWARD
After these reflections the members came up with the following suggestions to improve future immediate psychosocial and mental health interventions for persons affected by disaster and mass violence.

• Need for a coordinator for psychosocial response in Uganda. It was agreed that the office of the Principle Mental Health Officer of the Ministry of Health would coordinate this response. There is need for harmonization of the national strategy and hospital disaster plans as well as logistics and a budget for psychosocial response in case of any disaster. BasicNeeds was given this responsibility to write up a strategic policy document for psychosocial response in acute traumatic events in Uganda including ensuring follow up the affected survivors and their families through the relevant structures, proper handover and referral.

• Set up a psycho-trauma unit for victims in Mulago Hospital to supplement efforts in Butabika psychiatric hospital in order to give a sustained service in psychosocial support. This should include those for civil peacetime traumatic incidents like accidents, sexual and gender based violence, muggings, floods, earthquakes, land slides etc.

• Build capacity of staff members of the regional referral hospitals in mental health and psychosocial support and empower them to lead teams with the district mental health focal persons. Also build capacity to carry out rapid needs assessment of survivors as necessary. This implies to design a generic trauma assessment tool that can apply to any kind of trauma including that from natural disasters such as landslides, floods or earthquakes. To have an information leaflet in cases of mass emergency.

• Need for a clear interface between the patients, carers, counselors and health officers at the ward level and to continuously update the information on the survivors and for long-term follow up.

• Integrate psychosocial support into the training curriculum for all health workers, psychologists, social workers and counselors.

• The police and media also need to have continuous psychosocial support because these groups are always re-traumatized.

• There is a need for a meeting with the technical person at the Ministry of disaster preparedness to discuss emergency psycho-trauma responses. Dr. Sheila Ndyanabangi, as coordinator of Mental Health service for the Ministry of Health should coordinate this way forward including to have a MoH budget in place for emergency psychosocial interventions.

• A need for continuous review meetings, workshops and research regarding mass trauma involving all stakeholders.

REFERENCES


INTRODUCTION

In the wake of colonialism and thereafter, some countries in Sub-Saharan Africa have faced ongoing civil war and refugee crises. Consequently, some of the refugees develop severe mental disorders including post-traumatic stress disorder (PTSD) (American Psychiatric Association, 1994; Brunet et al., 2007). PTSD is a severe anxiety disorder that can develop after exposure to any event that results in psychological trauma (Satcher et al, 1999). The exposure event may involve the threat of death to oneself or to someone else, or to one’s own or someone else’s physical, sexual, or psychological integrity, overwhelming the individual’s ability to cope (Satcher et al, 1999).

Epidemiological studies have shown a higher than normal prevalence of depression and post traumatic stress disorder (PTSD) in refugee populations. Major depressive disorder is one of the most common diagnoses with some studies reporting prevalence of 29% in refugee populations (Mghir et al., 1995). A refugee camp survey of 993 Cambodians by Mollica et al. (1993) reported that 55% as symptomatic of depression and 15% of posttraumatic stress disorder (PTSD). Dinka and Nuer adult Sudanese who were interviewed using the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist-25 in USA were found to have high rates of exposure to trauma, yet this produced unexpectedly low aggregate scores for PTSD, depression, and anxiety (Fox and Willis, 2009).

CASE REPORT-I

A male refugee in Tanzania was referred for psychiatric evaluation because of persistent symptoms of sadness and fatigue. This 29-year-old man had never before developed a psychiatric problem until in 2002, during the civil strife when he developed similar symptoms that led to his admission in a hospital in the Democratic Republic of Congo (DRC) and was managed on a monthly injection of a long acting major tranquiliser—Fluphenazine decanoate 25mg i/m). He claimed that he improved on this medication. When he was reassessed in 2010, he gave the history of being the first born in a family of eight siblings, four brothers and three sisters. He has no family history of mental illness and both parents are alive and well.

He had a very good childhood and was liked by both parents and siblings. During this assessment in 2010, he presented to the author with talking to himself, had auditory hallucination (hearing people talking bad about him), depressed mood, withdrawn, lack of concentration, loss of interests in daily activities, terminal insomnia and fatigue. He denied suicidal ideations or attempts and the cognitive functioning was intact and he had good insight to his condition.

The physical examination was done and was essentially normal; the blood pressure was 125/83 mmHg. The current diagnosis is major mood disorder with psychotic features. He was started on Amitriptyline 50 mg nocte and Chlorpromazine 50mg nocte.

CASE REPORT-II

Mr. H. is a 54-year-old married man who is a refugee from DRC in Tanzania. During the interview he was calm, dressed reasonably well and answered the questions to the point. There is no family history of mental illness. He had a very good childhood.

The current condition started in 2007 during which he claimed to have been possessed by an evil spirit, that led to frequent attacks of being mute i.e. not being able to talk at all to anybody, had palpitations, profuse sweating, loss of memory, restlessness, fatigue and feeling of impending doom. This is a case of a Panic Anxiety Disorder, without agoraphobia. He was taken to faith healer who prayed for him as a result.
he recovered totally. When psychiatric assessment was done in 2010, he had no psychiatric symptoms suggestive of any mental illness. His cognitive functioning was intact and he had good insight to his condition. Physical examination revealed that he was hypertensive although his blood pressure was controlled at 130/86 mmHg taking medication atenolol 50mg tablet o.d.

CASE REPORT-III
Mr. B. is a 26-year-man refugee in Tanzania who was raised in DRC (Congo) who was referred for psychiatric assessment. He is single and one of five siblings, had a very good childhood and was liked by both parents and siblings. In 2005 both parents were murdered by militia gangs (the Mai Mai rebel group) in the Western Kivu Province during civil strife in DRC. During that time (2005) his primary symptoms were recurrent loss of memory, fainting attacks, tremors and startle reactions, persistent intrusive distressing images about the traumatic event, visual hallucinations of people who wanted to kill him including hearing voices of his parents calling him (auditory hallucination) for help as such he would become restless and began to cry profusely and was unable to control his emotions. He received treatment but did not know the type of medications he was put on. He was interviewed again in 2010, it was noted that he was calm and dressed reasonably well and answered the questions to the point. The history was obtained from himself and the brother. There is no family history of a mental illness. Compared to 2005 he reported improved condition, his cognitive functioning was intact and he had good insight to his condition. Physical examination was done and was essentially normal; the blood pressure was 132/81 mmHg. This a case PTSD and on a maintenance dose of chlorpromazine 100mg nocte which he claimed to be helping him very much what is bothering him now is his desire to get seek asylum in the USA.

DISCUSSION/CONCLUSION
Considerable psychological trauma in the all the respondents resulted in symptoms of PTSD, depression and anxiety as reported elsewhere in literatures (Brunet et al, 2007; Mghir, 1995; Mollica et al, 1993; Fox & Willis, 2009) and met DSM-IV-TR diagnostic R (American Psychiatric Association, 2005).
As a result of traumatic stress experienced during war and during their refugee status, victims were vulnerable and not well equipped to cope with either post-migration stressors in exile or with a return to their country of origin or with seeking asylum to third countries. The range of skills required of health professionals is broad and includes dealing with the psychiatric complications of humanitarian crises, war, and violence. Research is necessary among African refugees to determine similarities and differences with Western definitions of post traumatic psychiatric nosology. Such knowledge would inform the practice of mental health care in refugee camps in sub-Saharan Africa. The situation of mental health services among most refugee situations in sub-Saharan Africa is still poor as exemplified by this situation described by Debbie (2009) in Nakivale Refugee Settlement in 2003. Nakivale Refugee Settlement located in southwestern Uganda was one of Uganda’s eight “official” refugee camps. At that time 14,400 refugees were living at Nakivale, 12,000 who had fled the Rwandan massacres of the early nineties and over 500 refugees from Somalia’s 1991-1992 civil war. Basic somatic health care was available in this camp however refugees had no access to mental health services (Debbie, 2009).

REFERENCES
PREVALENCE AND CORRELATES OF PSYCHOLOGICAL DISTRESS AS SEEN IN POST-CONFLICT LIBERIA

Eugene Kinyanda, Mwaka Nakiboneka, Ojiambo Ochieng, Were-Oguttu, Gayflor V, Liebling-Kalifani, Howard Diawara

1. MRC/UVRI Uganda Research Unit on AIDS.
2. Isis-Women’s International Cross Cultural Exchange (Isis-WICCE), Uganda
3. Minister of Gender and Development of Liberia
4. Lecturer Clinical Psychology, University of Coventry, United Kingdom.
5. Coordinator Women In Peacebuilding Network (WIPNET/WANEP)

Abstract
Background: Sub-Saharan Africa continues to experience some of the worst cases of war trauma with Liberia one of the most severely war-affected nations in Africa. This war conflict leads to physical, psychological and sexual torture of the war survivors with devastating psychological, physical and social consequences. This study set out among other things to investigate the burden and correlates of psychological distress in four war affected counties of Liberia.

Methodology: A community-based survey was conducted in 4 war affected counties of Liberia, namely Bong (central Liberia), Lofa (far north west), Maryland (far east) and Grand Kru (extreme south east). This study was undertaken by Isis-WICCE in collaboration with WIPNET and the Ministry of Gender and Social Development of Liberia.

Results: The prevalence of significant psychological distress was 42.8%. At univariate analysis the factors associated with significant psychological distress in this study were multidimensional and included ecological, socio-demographic, war trauma, psychological and medical factors. At multiple logistical regression analysis the factors that remained significantly associated with above threshold psychological distress scores were county, age group, being stripped naked, watching someone being killed, denied toilet facilities, problem alcohol drinking and attempted suicide (in the last 12 months).

Conclusions: This study has demonstrated that war related physical, psychological and sexual trauma is associated with significant psychological distress suggestive of mental disorder.

Recommendations: Rehabilitation programs in conflict and post-conflict settings in sub-Saharan Africa should address the mental health wellbeing of these communities.

Background
Sub-Saharan Africa continues to experience some of the worst cases of war trauma with Liberia perhaps one of the most severely war-affected nations in Africa. Fourteen years of civil conflict in Liberia from 1989-2003 left a devastated war ravaged society that saw 250,000 persons killed, 500,000 displaced internally and about 800,000 of its 3.5 million inhabitants seek refuge in neighbouring countries (Background to the National Youth Policy, 2005). This war conflict led to the physical, psychological and sexual torture of the war survivors with devastating psychological, physical and social consequences (WHO, 2005; UNFPA, 2007; Johnson et al, 2008).

A recent study by Johnson and colleagues (2008) undertaken among a population based sample in Liberia noted that 9.2% of the females and 7.4% of the males had suffered some form of sexual violence. The rates of sexual violence were higher among former combatants, 42.3% among female combatants and 32.6% among male combatants. In that study the rates of psychiatric disorder were major depressive disorder (40%), post traumatic stress disorder (44%), and social dysfunction (8%) (Johnson et al 2008).

To respond to this burden of mental disorder, the Ministry of Health and Social Welfare of Liberia has included mental health as one of the components of the Liberian Basic Package of Health Service (BPHS) (Ministry of Health and Social Welfare, 2007). However operationalising the mental health component of the BPHS has been faced with severe lack of mental health professionals (Liberia has only one psychiatrist who is not in the public sector and only a handful of psychiatric nurses). The country has however put in place plans to address this including the development of a psychiatric nurse’s curriculum with the help of the Cater Centre and is due to undertake the training of its first cohort of psychiatric nurses with support from the Peter C Alderman Foundation.

As the country sets out to address the mental health needs of the population, there is need for a better understanding of the drivers of this burden. This study set out to investigate the burden and correlates of psychological distress in four war affected counties of Liberia.
METHODS
A community-based survey was conducted in 4 war affected counties of Liberia. The four study counties were selected to represent the different war experiences: Bong (to represent central Liberia), Lofa (to represent the far north western border area near Sierra Leone and Guinea), Maryland (to represent the far east bordering Cote d’Ivoire) and Grand Kru (to represent the extreme south eastern corner of the country). This study was undertaken by Isis-WICCE in collaboration with WIPNET and the Ministry of Gender and Social Development of Liberia.

Sample Size
The study employed a weighted proportional cluster sampling approach where the larger counties contributed proportionally more respondents than the smaller counties. The total sample size of individuals recruited into this study was 643 of whom 515(80%) were women and 128 (20%) were males. The sample size proportions were derived from the 2007 population projections based on a 2.4% population growth rate of the base year 2007 Country Assessment Survey Results.

Sampling Procedure
A multistage sampling procedure was used to draw up the study sample. During the first stage 1-2 districts were randomly selected from each study county. In each of the selected study district 4 villages were selected along passable roads but not beyond 40 kilometers from the town centre of that district. At the third stage of sampling, a female head of household or the oldest female member of the household was selected as the smallest enumeration unit. Only one woman was interviewed per household. A control group comprising of men at about 20% of study respondents was included in this study.

The Liberian settlement pattern is nuclear in nature with rural settlements within walking distance from the town or village centre. Therefore taking a linear pattern, each interviewer was allocated households each day, taking different directions in the north, south, east and west of the village/town centres, interviewing one respondent every after five households.

Preparation and calibration of data collection tools
A generic data collection tool which was translated into the main languages spoken in the study counties was pre-tested, adjusted and then used in this study. Non-medical interviewers were used in this study after adequate training and pilot testing of the research tools.

Research instruments
A structured questionnaire was used to screen the war survivors for war trauma and it is psychological and medical consequences. It included items on the following; a) Socio-demographics – change of location, sex, age, religion, marital status, highest educational attainment, and employment status, b) War trauma- derived from the commonly reported forms of war trauma as seen in previous Isis-WICCE studies in Uganda (Musisi et al, 2000) grouped under i) loss of loved ones (including loss of spouse, children, parents or other close relatives, ii) war related sexual violence - including single episode rape, gang rape, sexual comforting and abduction with sex, iii) physical trauma-including whether the respondent suffered beatings or being kicked, gunshot injury, burn injuries, being forced to carry heavy loads for long distances and severe tying of the hands behind the back (locally called Tibay), iv) psychological trauma - including whether the respondent witnessed someone being killed, ever being forced to sleep in the bush or swamps for days, weeks and whether ever abducted, c) Psychological consequences – including problem alcohol drinking assessed using the C.A.G.E where problem alcohol drinking was taken as having 2 or more positive items (Ewing, 1984), iii) psychological distress (assessed using the WHO Self Report Questionnaire-20, where significant psychological distress was taken as having 6 or more positive items (WHO, 1994), iv) suicide attempt (whether had attempted suicide in the last 12 month). e) Gynaecological problems (Isis-WICCE, 2001, 2002) - including leaking urine (vaginal fistula), leaking faeces (rectal fistula), vaginal and perineal tears, sexual dysfunction and abnormal vaginal discharge, f) Surgical problems (Isis-WICCE, 2001, 2002)- including chronic backache, broken limbs, disfigurement as a result of burns and swellings on limbs.

Data entry and analysis
Questionnaires were reviewed every evening for errors and inconsistencies which were then brought to the attention of the interviewers. Data was entered and analysed using SPSS version 10.0. Significant psychological distress was the dependent variable. As part of data analysis, frequencies were generated, and unadjusted analyses undertaken using Chi square and Odds ratios as the test statistics. Factors found to be significantly associated with war related sexual violence in unadjusted analyses were entered into multiple logistic regression analysis to determine their independent contribution to significant Psychological distress. For this multivariable analysis, a logistic regression model was fitted with a significance level of 0.10 so that all potentially important variables would be included in the model. The final model consisted of those factors that were significant at 0.05.
Ethical Considerations
Scientific and ethical clearance for the medical intervention and research was sought by the Ministry of Gender and Social Development of Liberia from the Ministry of Health and Social Welfare. Informed consent was obtained from the respondents after adequate explanation of the study procedures and both the immediate and anticipated benefits of the screening procedure/study.

RESULTS
Sample characteristics
843 respondents were screened for this study of whom 515 (80.1%) were women or girls. The gender ratios displayed in this study were predetermined at sampling as this study was predominantly designed to understand the medical, psychological and social effects of war on women (Isis-WICCE and WIPNET, the main sponsors of this study are Feminist organizations).

This analysis looks at the prevalence and correlates of psychological distress among post-conflict Liberians living in the four counties of Bong, Lofa, Grand Kru and Maryland.

In Table 1, majority (54.3%) belonged to the Kpelle tribe and were above 25 years (77%) with most (40.1%) having attained only an elementary level education. Majority (74.8%) were Christians and in monogamous marriages (46.5%).

Table 1: Socio-demographic characteristics associated with significant psychological distress among Liberians in four counties (N= 643)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>% of the Sample</th>
<th>Having above threshold psychological distress score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bong</td>
<td>290</td>
<td>45.1</td>
</tr>
<tr>
<td>Lofa</td>
<td>157</td>
<td>24.4</td>
</tr>
<tr>
<td>Maryland</td>
<td>122</td>
<td>19.0</td>
</tr>
<tr>
<td>Grand Kru</td>
<td>74</td>
<td>11.5</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>128</td>
<td>19.9</td>
</tr>
<tr>
<td>Female</td>
<td>515</td>
<td>80.1</td>
</tr>
<tr>
<td>Tribe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kpelle</td>
<td>349</td>
<td>54.3</td>
</tr>
<tr>
<td>Grebo</td>
<td>154</td>
<td>24.0</td>
</tr>
<tr>
<td>Kissi</td>
<td>53</td>
<td>8.2</td>
</tr>
<tr>
<td>Others</td>
<td>87</td>
<td>13.5</td>
</tr>
<tr>
<td>Age-group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;= 18 years</td>
<td>49</td>
<td>8.0</td>
</tr>
<tr>
<td>19-24 years</td>
<td>93</td>
<td>15.1</td>
</tr>
<tr>
<td>25-44 years</td>
<td>266</td>
<td>43.2</td>
</tr>
<tr>
<td>45+ years</td>
<td>208</td>
<td>33.8</td>
</tr>
<tr>
<td>Educational Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal education</td>
<td>202</td>
<td>32.0</td>
</tr>
<tr>
<td>Elementary</td>
<td>253</td>
<td>40.1</td>
</tr>
<tr>
<td>Junior high</td>
<td>140</td>
<td>22.2</td>
</tr>
<tr>
<td>Senior high and above</td>
<td>36</td>
<td>5.7</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>480</td>
<td>74.8</td>
</tr>
<tr>
<td>Islam</td>
<td>37</td>
<td>5.8</td>
</tr>
<tr>
<td>African Traditional religion</td>
<td>31</td>
<td>4.8</td>
</tr>
<tr>
<td>Others</td>
<td>94</td>
<td>14.6</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married-monogamous</td>
<td>275</td>
<td>46.5</td>
</tr>
<tr>
<td>Married-polygamous</td>
<td>69</td>
<td>11.7</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>9</td>
<td>1.5</td>
</tr>
<tr>
<td>Co-habiting</td>
<td>86</td>
<td>14.6</td>
</tr>
<tr>
<td>Widowed</td>
<td>103</td>
<td>17.4</td>
</tr>
<tr>
<td>Single</td>
<td>87</td>
<td>13.6</td>
</tr>
<tr>
<td>Remarried</td>
<td>13</td>
<td>2.2</td>
</tr>
</tbody>
</table>
Socio-demographic factors associated with psychological distress

Using a cut-off point of 6 and above to indicate significant psychological distress scores on the WHO Self Report Questionnaire-20 (a cut-off point validated by Nakigude et al, 2005 in Uganda a socio-cultural context similar to that in Liberia) up to 42.8% of the respondents had significant psychological distress indicative of mental illness.

Table 1, the socio-demographic factors associated with significant psychological distress scores in this study were: county [highest in Maryland (61.5%) and GrandKru 96.3.5%), lowest in Bong (34.8%) and Lofa (33.1%); \(X^2 = 43.89; df=3; p=<0.001\)]; tribe [highest in Grebo (63.0%), lowest in Kpelle (32.4%); \(X^2 = 42.20; df=3; p=<0.001\)]; age group [increasing with age group; highest among those aged 45 year and above (56.3%), lowest in those <=18 years (16.3%); \(X^2 = 35.63; df=3; p=<0.001\)]; highest educational attainment [highest among those who had senior high and above level (61.1%) and among those with no formal education (52.5%), lowest in those with elementary level (36.4%) and junior high level (35.7%); \(X^2 = 19.81; df=3; p=<0.001\)]; religion [highest among Christians (49.4%), lowest among those belonging to African traditional religion (12.9%); \(X^2 = 35.86; df=3; p=<0.001\)]; marital status [highest in the divorced/separated (66.7%) and widowed (55.3%), lowest among the single (35.6%) and the monogamous-married (37.8%); \(X^2 = 15.19; df=6; p= 0.019\). In this study gender was not significantly associated with above threshold psychological distress scores.

Psychosocial Characteristics

Table 2, on war trauma, the most reported physical trauma events were forced labour (69.8%) and deprivation of food/water (60.5%). On psychological trauma events, the most reported events were sleeping in the bush for extended periods of time (82.6%), loss of property/livestock (63.3%), witnessing someone being killed (62.2%) and being detained by rebels (62.4%). On loss of relatives, 33.2% of women reported loss of a husband; 50.8% of the men reported loss of a wife and 40.6% of all respondents reported loss of child(ren). On sexual trauma among the women, 15.6% reported single episode rape, 11.6% reported gang rape, 16.7% attempted rape, 26.8% defilement and 7.1% abduction with sex.

On psychosocial and medical problems, 12% had problem alcohol drinking (a positive CAGE), 12.8% had attempted suicide in the last 12 months, 73.0% of the women reported at least one gynecology complaint (most commonly chronic lower abdominal pain (37.1%), leaking urine 21.6% and infertility

22.3%), 61.4% of all respondents had at least one surgical complaint (most commonly backache (55.8%), pains in the joints (50.9%) and swellings of the limb(s) (11.5%).

Psychosocial factors associated with psychological distress

Table 2, shows the psychosocial factors associated with significant psychological distress scores in this study. On war trauma factors these were: deprivation of food/water 2.3 (1.7-3.2), deprivation of medicine 2.7(2.0-3.8), being stripped naked 2.5(1.8-3.5), denied toilet facilities 6.2(4.3-9.0), denied sleep 2.9(2.1-4.0), witnessing the cutting of body parts 2.1(1.4-3.1), loss of property/livestock 2.4(1.7-3.4), loss of non-spouse, non-child, non-parent, relative 1.7(1.3-2.5) and rape (single episode).

On psychosocial complaints problem alcohol drinking 2.5 (1.5-4.1) and having at least one surgical complaint 2.0 (1.4-2.8) were associated with psychological distress. Having at least one gynecological complaint and attempted suicide (in last 12 months) were not significantly associated with psychological distress.

Multiple logistical regression model of factors associated with significant psychological distress

African Journal of Traumatic Stress Vol 1 No.2 December 2010
Table 2: Psychosocial factors associated with significant psychological distress among Liberians in four counties (N= 643)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>% of the Sample</th>
<th>Hiving above threshold psychological distress score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Physical trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beating/kicking</td>
<td>407</td>
<td>63.3</td>
</tr>
<tr>
<td>Bayonet/knife/spear injury</td>
<td>192</td>
<td>29.9</td>
</tr>
<tr>
<td>Forced labour</td>
<td>436</td>
<td>67.8</td>
</tr>
<tr>
<td>Severe tying (Tibay)</td>
<td>155</td>
<td>24.1</td>
</tr>
<tr>
<td>Deprivation of food/water</td>
<td>389</td>
<td>60.5</td>
</tr>
<tr>
<td>Deprivation of medicine</td>
<td>336</td>
<td>52.3</td>
</tr>
<tr>
<td>Burning with molten plastic</td>
<td>131</td>
<td>20.4</td>
</tr>
<tr>
<td>Gunshot injury</td>
<td>190</td>
<td>29.5</td>
</tr>
<tr>
<td>Landmine injury</td>
<td>158</td>
<td>24.6</td>
</tr>
<tr>
<td>Hanging</td>
<td>125</td>
<td>19.4</td>
</tr>
<tr>
<td>Being stripped naked</td>
<td>223</td>
<td>34.7</td>
</tr>
<tr>
<td>Suffocated with red pepper</td>
<td>147</td>
<td>22.9</td>
</tr>
<tr>
<td>Denied access to toilet facilities</td>
<td>201</td>
<td>31.3</td>
</tr>
<tr>
<td>Psychological trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denied sleep</td>
<td>326</td>
<td>50.7</td>
</tr>
<tr>
<td>Witnessed cutting of body parts</td>
<td>129</td>
<td>20.1</td>
</tr>
<tr>
<td>Detained by the army</td>
<td>196</td>
<td>30.5</td>
</tr>
<tr>
<td>Detained by rebels</td>
<td>401</td>
<td>62.4</td>
</tr>
<tr>
<td>Detained by militias</td>
<td>250</td>
<td>38.9</td>
</tr>
<tr>
<td>Slept in the bush for extended periods of time</td>
<td>531</td>
<td>82.6</td>
</tr>
<tr>
<td>Abducted</td>
<td>319</td>
<td>49.6</td>
</tr>
<tr>
<td>Lost property/livestock</td>
<td>407</td>
<td>63.3</td>
</tr>
<tr>
<td>Forced to join fighting groups</td>
<td>107</td>
<td>16.6</td>
</tr>
<tr>
<td>Forced to kill against will</td>
<td>32</td>
<td>5.0</td>
</tr>
<tr>
<td>Witnessed killing of others</td>
<td>400</td>
<td>62.2</td>
</tr>
<tr>
<td>Loss of family/close relatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of husband (n=515)</td>
<td>171</td>
<td>33.2</td>
</tr>
<tr>
<td>Loss of wife (n=128)</td>
<td>65</td>
<td>50.8</td>
</tr>
<tr>
<td>Loss of parent</td>
<td>259</td>
<td>40.3</td>
</tr>
<tr>
<td>Loss of children</td>
<td>261</td>
<td>40.6</td>
</tr>
<tr>
<td>Loss of other relatives</td>
<td>374</td>
<td>58.2</td>
</tr>
<tr>
<td>Sexual trauma (data collected among women only n= 448)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape (single episode)</td>
<td>70</td>
<td>15.6</td>
</tr>
<tr>
<td>Gang rape</td>
<td>52</td>
<td>11.6</td>
</tr>
<tr>
<td>Attempted rape</td>
<td>75</td>
<td>16.7</td>
</tr>
<tr>
<td>Forced marriage</td>
<td>66</td>
<td>14.7</td>
</tr>
<tr>
<td>Defilement</td>
<td>120</td>
<td>26.8</td>
</tr>
<tr>
<td>Abduction with sex</td>
<td>32</td>
<td>7.1</td>
</tr>
<tr>
<td>Psychological/Medical problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem drinking of alcohol</td>
<td>77</td>
<td>12.0</td>
</tr>
<tr>
<td>(CAGE positive)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attempted suicide (past 12 mths)</td>
<td>82</td>
<td>12.8</td>
</tr>
<tr>
<td>Having at least one surgical problem (self report)</td>
<td>395</td>
<td>61.4</td>
</tr>
</tbody>
</table>

*Statistical significance set at 0.001 after a Bonferroni correction(0.05/38)
Table 3: Final logistical regression model of factors associated with significant psychological distress

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Wald</th>
<th>Adjusted Odds Ratio</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ecological factors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County</td>
<td>15.33</td>
<td>1.37</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td><strong>Socio-demographic factors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age group</td>
<td>9.85</td>
<td>1.48</td>
<td>0.002*</td>
</tr>
<tr>
<td>Religion</td>
<td>3.20</td>
<td>0.82</td>
<td>0.074</td>
</tr>
<tr>
<td><strong>War trauma factors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stripped naked</td>
<td>4.36</td>
<td>1.68</td>
<td>0.037*</td>
</tr>
<tr>
<td>Watch someone being killed</td>
<td>10.25</td>
<td>2.01</td>
<td>0.001*</td>
</tr>
<tr>
<td>Denied toilet services</td>
<td>49.15</td>
<td>4.71</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td><strong>Psychosocial problems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem alcohol drinking</td>
<td>6.14</td>
<td>2.10</td>
<td>0.013*</td>
</tr>
<tr>
<td>Attempted suicide in last 12 months</td>
<td>21.41</td>
<td>4.26</td>
<td>&lt;0.001*</td>
</tr>
</tbody>
</table>

At multiple logistical regression analysis of the factors that were significantly associated with above threshold psychological distress scores could be grouped into four categories: ecological factors (county), socio-demographic factors (age group), war trauma factors (stripped naked, watching someone being killed, denied toilet facilities), and psychosocial factors (problem alcohol drinking and attempted suicide - last 12 months).

**DISCUSSION**

This paper set out to determine the prevalence and correlates of significant psychological distress in post-conflict Liberia. The results of this study showed that post-conflict Liberian society had a considerable burden of psychological distress suggestive of mental illness of 42.8%. The results of this study confirm the magnitude reported in previous studies undertaken in both Liberia and other war affected societies in Africa (Johnson et al, 2008; WHO, 2005; Mwaka Nakiboneka et al, 2007; Kinyanda et al, 2006; Kinyanda and Musisi, 2001). A recent study in Liberia reported a prevalence of major depressive disorder of 40% and post traumatic stress disorder of 44% (Johnson et al, 2008).

The socio-demographic factors that were associated with significant psychological distress were tribe, increasing age, educational attainment (highest among those with high and very low educational attainment), religion (highest among Christians and lowest among those with African traditional religion), marital status (highest among the divorced/separated and widowed) with only age retaining statistical significance at multivariate analysis. Previous studies in war affected communities have reported a similar association between socio-demographic factors and psychological distress. Kinyanda and Musisi (2001) in Gulu district in Northern Uganda reported that marital status (being divorced/separated and being widowed) and educational attainment (highest educational attainment) were significantly associated with psychological distress. In this study unlike studies elsewhere (Kinyanda and Musisi, 2001; Mwaka Nakiboneka et al, 2007; Kinyanda et al, 2006), gender was not significantly associated with psychological distress. The reasons for the absence of this expected gender difference were however not immediately clear.

War related trauma that was physical (such as deprivation of food/water, deprivation of medicine, being stripped naked), psychological (such as denied toilet facilities, denied sleep, witnessing the cutting of body parts) and sexual (such as single episode rape) were significantly associated with psychological distress. At multivariate analysis only being stripped naked, watching someone being killed and being denied toilet facilities retained significance with psychological distress. The association between physical, psychological and sexual trauma with psychological distress has previously been reported elsewhere (Kinyanda and Musisi, 2001; Mwaka Nakiboneka et al, 2007; Kinyanda et al, 2006; Kadenic, 1998; Johnson et al, 2008; Skylyv, 1992).

The factors associated with significant psychological distress in this study were multidimensional and included ecological, socio-demographic, war trauma, psychological and medical factors. On ecological factors, the county was significantly associated with psychological distress, a relationship that retained significance at multivariate analysis. County seemed to represent as yet undefined ecological characteristics.

Previous studies in Uganda by both Kinyanda and colleagues (2009) and Vink and colleagues (2007) have noted similar geographic variations in rates of depression that could not readily be explained.
The psychosocial complaints of problem alcohol drinking, attempted suicide and having at least one surgical complaint were significantly associated with psychological distress. The relationship between psychological distress on one hand and problem alcohol drinking and attempted suicide on the other retained significance at multivariate analysis. Both problem alcohol drinking and attempted suicide in a war affected population have previously been associated with psychological distress (Kinyanda et al, 2006).

CONCLUSIONS AND RECOMMENDATIONS

In conclusion, this study has demonstrated that war related physical, psychological and sexual trauma is associated with significant psychological distress suggestive of mental disorder. The implications of this finding is that war trauma directly contributes to the burden of mental health disorders in conflict and post-conflict settings in Africa.

As a recommendation, rehabilitation programs in conflict and post-conflict settings in sub-Saharan Africa should address the mental health wellbeing of these communities.

ACKNOWLEDGEMENTS

We would like to thank Isis-WICCE, WIPNET and the Ministry of Gender and Development of Liberia for facilitating this study. For funding this study we thank Evangelischer Entwicklungsdienst (EDD), ICCO en Kerkinaakte, Norwegian Council for Africa/Focus, Open Society Institute, Sigrid Rausing Trust and Amnesty International.

REFERENCES

11. Nakigudde J (2005): A study to validate the WHO SRQ-20 in the Ugandan setting. A study funded by SIDA/SAREC.
The Nigerian Niger Delta Region (NDR) of Nigeria is made up of nine states - Abia, Akwa Ibom, Bayelsa, Cross river, Delta, Edo, Imo, Ondo and Rivers states. Altogether, the states form a large expanse of wetlands, mangrove forest, swampland, and fresh water eco-system with a large network of creeks, rivers, streams, ox-bow lakes and fertile lands. The Niger Delta area has a total population of about 20 million people. The main ethnic nationalities in the Niger Delta are; the Ijaws, Okrika, Andoni, Urhobo, Kalabari, Ibibio, Itsekiri, Ikwere, Igbo and Yoruba. The Ijaws form about 60% of the population of people living in the Niger delta Region. Before the discovery of oil in commercial quantities at Oloibiri (Bayelsa state) in 1958, the people living in the NDR were mostly fishermen. In fact, the region accounted for a large percentage of Nigeria's commercial fisheries industry (Afinotan et al, 2009). It is reported that underneath the Niger Delta area, there are about 35 billion barrels of crude oil reserves, and twice that amount of untapped natural gas. In light of this, 80% of Nigeria's Gross Domestic Product (GDP) is from these oil reserves and from export of crude oil which originates from the NDR.

It can therefore be reasonably deduced that the NDR has sustained the Nigerian economy since the early 1960s. Drilling of oil has been observed to cause frequent oil spills, which pollutes the water in the NDR. This in turn causes destruction of fish and aquatic life, obliteration of crops and devastation of the eco-system. The health of the population has not been spared. The daily flaring of gases associated with petroleum drilling activities in the NDR is known to lead to poisoning of the lungs, causing pulmonary diseases, noise pollution and stunted growth among the children. In addition, there is loss of livelihood as well as migration of wildlife and spread of water borne diseases. The wanton destruction of farmland and loss of employment over the years have caused diseases, hunger and poverty. The water in the NDR is now reported to be dangerously acidic (Afinotan et al, 2009). Despite the frequent protests against the observed destruction of lives and property through the activities of oil companies and proclamations of local and foreign environmental activists like those by the late Isaac Adaka Boro and Ken Saro Wiwa, there has not been any deliberate attempt by the companies to rectify the damage to the NDR environment. Similarly, there has not been any consideration of the people living within the area for meaningful assistance. Even now, there are no properly manned and equipped secondary and tertiary hospitals to manage the diseases common in the NDR environment. In the last 40 years, more than 60,000 oil spills were recorded, and more than two million barrels of oil were observed to have been discharged into the region's eco-system. In 2008, 418 spills were recorded (Afinota et al,
2009). Neither the government nor the companies paid compensation for the devastation caused by oil drilling and gas flaring.

The genesis of the conflict

The reasons adduced for the agitation by the militants in the NDR of Nigeria are: a search for alleviation of poverty, education, employment for the youths, removal of environmental pollution, provision of hospitals and other social amenities, enhancement of socio-political participation, reduction of environmental degradation and a stoppage of the apparent neglect by the federal government of Nigeria. One of the most active militant group in the NDR is the Movement for the Emancipation of the Niger Delta (“MEND”).

In this light, the insurgency is a movement of protests against social and political hopelessness and the sense of oppression by the Nigerian state. The insurgency by the NDR militants has been variously referred to as the Niger Delta crisis by the Nigerian government. The crisis is associated with widespread anxiety among the citizens living in the NDR and all over Nigeria. The militants are known to kill political opponents, kidnap prominent people for ransom, attack oil pipe lines, and sexually assault young women living within the NDR. For these reasons, the NDR became an unsafe area for living and for any legitimate business to thrive.

Sociologists and political scientists have reported that the insurgency could be explained from the point of view of the frustration-aggression theory in which the tension builds up when there is a gap between the levels of expectation and attainment. Ken Saro Wiwa (Wiwa, 2002) observed and reported that there were more than 3000 cases of gun violence, 250 deaths, more than 100 amputations, and many cases of rape in his native Ogoniland. The healthcare system has not been immune to the ravages of the conflict. The hospitals have been over-stretched beyond their capacity. Poorly equipped, with ill-trained and unmotivated staff, health facilities have continued to render very low quality health care to the people of the region. The security situation also means that many of the best brains in the land did not feel it safe to make a life in the region, and preferred to migrate to other parts of the nation such as Lagos, Abuja and Western countries. Despite the fact that the whole population in the NDR is under severe and sustained mental strain, the mental health services have continued to be minimal and rudimentary. Although there are psychiatric hospitals in Benin, Enugu, Port Harcourt and also psychiatric units in some teaching hospitals within the region, these services are known not to exist at primary care level, which is the most accessible level of service for most of the populace. Treatment in the specialist centres is known to be relatively expensive and unaffordable for many in the population. Specialists centre are also known to be located far from most people hence making it difficult for people to travel long distances from their homes. With the expansion of the conflict both in scope and intensity, internally displaced families fleeing the fighting have become a common a feature of the story.

The relationship between traumatic social events and mental health

The impact of traumatic life events such as wars, insurgency, ethnic disturbances on the mental health of citizens and the need to develop strategies to deal with them is well documented in literature. Immigrant Latinos in the United States of America have been known to show evidence of psychological trauma attributable to political violence (Fortuna et al, 2008). Palestinian children have been found to show evidence of increased aggression (Dubow et al, 2010). Exposure to persistent ethnic political violence has had a major impact on children’s psychological adjustment (Dubow et al, 2009). Exposure to household violence and human rights violation in Bangladesh was reflected in the functional assessment of victims (Wang, 2009). Survivors of the war in Northern Kosovo showed physical and psychological evidence of impairment (Wang et al, 2010). Refugees repatriated from Germany showed mental health problems (Lersner, 2008).

The concept of ‘collective trauma’ was introduced to describe the situation suffered by a whole population playing host to war or insurgency, such as northern Sri Lanka (Somasundaram, 2007). Sexual violence – specifically rape, is an indispensable factor in collective trauma (Steiner et al, 2009). Different forms of interpersonal violence, such as that experienced in a high-crime society such as South Africa, are associated with an increased risk of post-traumatic stress disorder (Kraminer et al, 2008). Refugee children are vulnerable to the effects of pre-migration exposure to trauma (Montgomery, 2008). Some such children have been shown to have observable benefits from primary health care corrective interventions focussed on play (Miller et al, 1994). Victims and survivors of massive traumatic events suffer mental health consequences that go beyond standard descriptions such as PTSD (Pederson et al, 2008).

What has the federal government of Nigeria done?

In 1990, the military regime of General Ibrahim Babangida created the Oil Minerals Producing Areas Development Commission (OMPADEC) to attempt to look into the NDR agitation and also bring about a resolution. A successor government set up the Niger Delta Development Commission (NDDC) in 1999 which attempted to implement the recommendations of OMPADEC. These two bodies were apparently well-meant but failed to make the much needed impact. Mental health services in the NDR in particular and physical healthcare in general remained inadequate.
This was largely due to corruption and mismanagement of funds meant for the development of the NDR. Nonetheless, the government of the late President Yar Adua created a Ministry for the Niger Delta. A Niger Delta Commission was also set up to bring about changes within the NDR. Due to largely the efforts of these two new bodies, a general amnesty was granted to all the militants operating within the NDR. In all, about 30,000 militants laid down their arms. The government promised to rehabilitate the militants by providing them with a monthly salary; accommodation at various camps, and education and other inputs that would remove the need that drove them to take up arms against the government. The only lacking aspect of the intervention was deliberate efforts to manage the mental health needs associated with participation in the conflict of former belligerents. It was therefore no wonder that within the first three months of the amnesty, some of the ‘repentant’ militants revolted, destroying properties and raping some university students who were in an institution close to their camp.

**The Role of the Psychiatrist and other mental health practitioners**

About 30,000 militants, mostly youths from the nine states that make up the NDR were given general amnesty by the federal government of Nigeria. These militants had hitherto lived in creeks and lived the lives of brigands and soldiers at war. It would be expected that a significant proportion of them would manifest forms of psychopathology such as anxiety, depression, post traumatic stress disorders, borderline and sociopathic personality disorders, occasional psychotic syndromes and multiple drug misuse (Thomas et al, 2010; Bray et al, 2010). It is no surprise therefore that the need for mental health workers and mental health service facilities is immense.

**Psycho-social problems likely to be associated with the Niger Delta insurgency in the community**

There are primary problems which include: poverty, deprivation, resentment, lack of faith in government or oil companies on account of neglect and broken promises.

There are also secondary problems which include: psycho-trauma in kidnapped victims and families of victims of the kidnapped individuals, a mental siege mentality for entire communities; rampant criminals masquerading as political agitators; excesses of law enforcement agencies and corruption among the law enforcement agents.

**Problems arising from reconciliation process**

There is psychological trauma experienced by insurgents and the general populace as well as rising crime associated with a poorly designed rehabilitation programme.

**A critique of the reconciliation programme**

We are now in a position to make a well-reasoned critique of the reconciliation process in the Niger Delta of Nigeria. The whole reconciliation process, while well-intentioned, was initially designed by politicians, without any evidence of significant input mental health professionals like; psychiatrists, psychologists and sociologists. Inclusion of mental health professionals would have helped to mainstream mental healthcare in the reconciliation programme. The original focus was on disarmament. The government’s interest seems to have been in ‘peace’ as defined by the absence of fighting and kidnapping. This was required to get the oil flowing again, and restore financial buoyancy to the government. It was also a good public relations move, designed to boost the government’s image locally and in the international community. No consideration was given to the mental health consequences of experiences associated with the conflict, or mental health requirements in the reconciliation process itself. Existing mental health resources, already scanty and overstretched, were not strengthened in anticipation of additional pressure arising from conflict-related psycho-trauma.

**Consequences of absence of Mental Health input or focus**

Despite its political necessity for the future of Nigeria, and the huge resources committed to it, the whole process appears to be faltering. Some of the observers have said that people have become or became terrified of having make-shift ‘rehabilitation camps’ within their neighbourhoods, for good reason. For instance, the ‘insurgents’ were often disgruntled and unruly. A detachment of “rehabilitated militants” camped near the University of Port Harcourt invaded the University and sexually assaulted several of the female students, leading to a public outcry. The planners had not anticipated that the insurgents would have any other need other than to be paid the agreed monthly stipend, which was rather generous by Nigerian wage standards. The use of psychological ‘debriefing’ and counselling as part of the rehabilitation effort was not considered.

**CONCLUSION AND RECOMMENDATIONS**

It is necessary to design and implement a comprehensive mental health promotion model for dealing with individual and collective psycho-trauma in the Niger Delta of Nigeria. Time and momentum have been lost due to the failure to have a good working model in place at inception. Psychiatrists
and Psychologists need to be urgently involved in drawing up an effective programme of rehabilitation and reintegration that will include individualised baseline assessment of need, and provision of service, including psychiatric and psychological treatment and support where this is required. The Occupational therapists are needed to teach skills to those who lack vocational skills to create the possibility that the individual will be able to lead a meaningful independent existence. Assisted and supervised employment and long term social case work will be required to sustain the gains of the process. Amenities such as clean water, electricity, education and good primary and secondary health care services would need to be provided to make the lives of the generality of the people bearable – a central feature of the original grouse that led to the insurgency. It is important that the rest of Africa, and the world, learn from the travails of the Niger Delta and the problems caused by faulty planning in devising rehabilitation strategies, and that an agreed standard protocol for dealing with such challenging social problems be developed.

REFERENCES


THE AFRICAN ASSOCIATION OF PSYCHIATRISTS AND ALLED PROFESSIONALS (AAPAP) ANNUAL CONFERENCE

The African Association of Psychiatrists and Allied Professionals (AAPAP) in conjunction with the Kenya Psychiatric Association and the World Psychiatric Association, invites you to the annual scientific conference to be held in Nairobi on 25th - 27th August 2011.

CONFERENCE THEME: MENTAL HEALTH IN AFRICA - EMERGING CHALLENGES

SUB-THEMES

<table>
<thead>
<tr>
<th> </th>
<th>Alcohol and Drug Abuse: Imminent Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td> </td>
<td>Substance Use Disorder and HIV</td>
</tr>
<tr>
<td> </td>
<td>Advocacy for Mental Health</td>
</tr>
<tr>
<td> </td>
<td>Mental Health in Special Populations (e.g. refugee and prison populations)</td>
</tr>
<tr>
<td> </td>
<td>Mental Health financing</td>
</tr>
<tr>
<td> </td>
<td>Mental Health Research and Capacity Building</td>
</tr>
</tbody>
</table>

Please visit the website [www.psychiatrykenya.com](http://www.psychiatrykenya.com) for details on the conference organisation and important deadlines for submission of abstracts.


PLEASE NOTE THESE IMPORTANT DATES:

Deadline for submission of abstracts: 31 May 2011
Response to Authors: 30 June 2011
Final Conference Program: 31 July 2011

Please feel free to send in your abstracts as indicated on the website.

Dr Lukoye Atwoli,
Convener, Scientific Committee.
Moi University School of Medicine,
P.O.Box 1493, Eldoret 30100.
[www.lukoyeatwoli.com](http://www.lukoyeatwoli.com)
Peter C. Alderman Foundation Fourth Regional Conference on Psychotrauma

AFRICAN INTERNATIONAL PSYCHOTRAUMA CONFERENCE & TRAINING
Theme: MENTAL HEALTH POLICY AND PRACTICE ON PSYCHO TRAUMA:
African Solutions to African Problems
11th JULY – 15th JULY 2011
NAIROBI, KENYA

Venue: The Catholic University of Eastern Africa in Nairobi
(CUEA)

HOSTED BY:

Conference Email: psychotrauma2011@amhf.or.ke
Conference Website: www.africamentalhealthfoundation.org
Telephone Contacts: +254-20-2716315 (Landline – during normal working hours)
Mobile contacts: +254 722 518 365 /+254 751 014 846 /+254 720 957 477

Makerere University
College of Health Sciences
P.O.Box 7072
Kampala, Uganda