Bereavement recovery following the Rwandan genocide

A community-based intervention for child survivors

Leila Gupta PhD, MSW, MPH
UNICEF Consultant, Children and War
UNICEF Trauma Programme, Rwanda

Five years after the Rwandan genocide when 800,000 children and adults were violently massacred using primitive methods, the survivors continue to address their traumatic memories and grief reactions. The Trauma Recovery programme provides information, training, and psychotherapeutic services to bereaved individuals, families and communities throughout the country. Set up with the help of UNICEF, the programme is administered through the Rwandan Ministry of Health.

The socioeconomic and psychological consequences of warfare are devastating and the greatest impact is felt among children – the most vulnerable members of society. Recent studies indicate that exposure to war-related violence is often harmful to children's personality development, self-esteem, coping abilities, and interpersonal functioning[1-7]. In addition, the traumatic stress and bereavement adaptation literature suggests that sudden, violent deaths, in which the survivors witness atrocities like those that occurred in Rwanda, often produce problematic grief reactions because of the nature of the losses and the presence of post-traumatic stress disorder. Thus, the bereavement process may be more prolonged or complicated[8, 9]. In response to the suffering of Rwandan child survivors in the aftermath of the genocide, UNICEF and the Ministry of Rehabilitation, in collaboration with several non-governmental organisations, initiated a psychosocial recovery programme in October 1994.

The Rwandan Trauma Recovery programme is a nationwide, community-based psychosocial intervention targeting bereaved and traumatised children and their caretakers. The major objective of the programme is to strengthen the national capacity among lay people and para-professionals to deal with the effects of the violence by providing information, emotional support and training. The programme also documents survivors' stories, provides outpatient clinical treatment for severely traumatised children and families at a National Trauma Center, and conducts longitudinal research, in collaboration with the Children and War Consortium in Bergen, Norway. Initially the UNICEF-supported programme focused on assisting separated and/or orphaned children and those attending school by making their caretakers and teachers aware of traumatic stress and grief reactions and of culturally appropriate methods of expressing grief, and by helping them to make referrals for clinical treatment when necessary.

At present, the Trauma Recovery Programme is administered and supported through the Division of Mental Health Services at the Ministry of Health. It is operational in 10 of the 12 prefectures (regions) throughout the country. The outpatient clinic, training, and research facilities which were sited at the National Trauma Center, from 1995-98, were recently relocated in 1999 to the Ministry of Health offices in the capital, Kigali.

EDITOR'S NOTE

A year after the appalling genocide in Rwanda, which was followed by a successful conquest by the armies of the 'Rwandan Patriotic Front', Leila Gupta, and a small group of psychologists and other professionals from Norway, were invited by UNICEF and the Rwandan government to set up a trauma recovery programme. Having visited Rwanda and met the people involved (*Bereavement Care* 1995; 14: 34-36) your editor is proud to applaud the work that they are doing and to publish this account of the research on which it was based, the way in which the programme was set up and the impressive results that were achieved. This was not cultural imperialism but a culturally-sensitive attempt to meet the desperate needs of a society in which most children have witnessed acts of violence, a majority have lost family members and a third have seen their own parents or siblings being killed. Trauma such as this scars those who experience it and may even sow the seeds of further violence. It follows that anything which ameliorates the trauma may also break the cycle of violence that has beset Rwanda during the last 40 years.

CONCEPTUAL FRAMEWORK

The nature and magnitude of the exposures to traumatic events, as well as the ensuing psychological reactions evident in the population at one and two years post-genocide (assessed by the National Baseline Trauma Survey, 1996, and the Follow-up Survey, 1998), indicated the national strategy we should develop[10]. It was essential that our efforts be aimed at empowering the Rwandese people to heal their own traumas using traditional methods of intervention such as story-telling, drawing and role playing, to ensure long-term sustainability and facilitate reconciliation. Within this framework, psychological trauma was viewed as a universal human response to an extremely stressful event (ie the genocide).

OPERATIONAL MODEL

Local level organisation

At the local level, the Trauma Programme is currently implemented through 10 social agents called trauma advisers. The trauma advisers have academic backgrounds in nursing, social work, and education, in addition to completing a four-week training course in child development, normal grief

reactions, trauma theory, listening skills and basic methods of trauma alleviation. They are given guidelines for training local social agents. The trauma advisers are required to live and work in their respective prefectures so they can establish credibility within the local community. Each trauma adviser is based at the District Health Officer's headquarters where they share an office as well as the governmental linkage with the Ministry of Health.

The primary role of the trauma advisers is to help the local populations by training Rwandan teachers, health workers and caretakers to be aware of the psychosocial effects of war-related violence on children and adults. Various social agents are invited to participate in a two or three day training session with their regional trauma adviser.

After the session, most of the trainees are able to provide direct assistance to the children in their local communities. The training sessions enable participants to recognise the symptoms of post-traumatic stress; identify grief reactions and use basic methods of trauma alleviation; offer emotional support; and help to refer on where necessary. The trauma advisers are supervised by the Ministry of Health, where they attend monthly staff meetings to exchange information and receive in-service training and support.

National level organisation

The Trauma Recovery Programme is administered at the national level through the government Division of Mental Health Services in Kigali. The team – the programme director, administrative staff, research adviser, and clinical team, consisting of a child psychiatrist, nurse clinician and two social workers – are all at the Ministry of Health. All clients referred to the out-patient clinic by the trauma advisers receive free evaluation and treatment. In general, most child survivors and their caretakers receive between four and six sessions at the clinic. In addition, many adult survivors who walk into the clinic from the streets also receive free treatment. Severely traumatised and/or bereaved people who require in-patient psychiatric treatment are referred to Ndera Hospital in Kigali, which is the only in-patient psychiatric facility in Rwanda.

SITUATIONAL CONTEXT

In addition to the destruction of the physical and socioeconomic infrastructure immediately after the genocide, the Rwandan people faced overwhelming social and interpersonal losses, as well as a persistent sense of insecurity that the killers would someday return to 'finish the job and fill the graves', as they promised. The entire social fabric was decimated and there was no social service system available to assist the survivors. Moreover, nearly two and a half years after the genocide when more than 2.5 million Hutu refugees returned to Rwanda from the Democratic Republic of Congo and Tanzania, a resurgence of Tutsi killings occurred and many of the survivors' traumatic memories and grief reactions resurfaced. Finally, five years after the genocide, nearly 150,000 men, women and youths accused of participating in the killings remain in Rwandan prisons, while only a handful of them have been tried and convicted by the international tribunal.

NATURE OF EXPOSURES

The violence that occurred in Rwanda was different in several ways from other war-related traumatic exposures. First, the types of weapons used in the massacres were quite primitive, such as machetes, nail-studded clubs, and sticks. Thus, the perpetrators were often face-to-face with their victims, unlike the highly technological warfare that recently occurred in the Balkans. Secondly, most of the killings took place in the victims' homes, schools and churches, and the violence was perpetrated by neighbours, local youths, religious leaders, government officials and trusted adults who often knew the victims. Finally, the magnitude and scale of the killings that occurred in Rwanda between April and July 1994 resulted in unprecedented levels of exposure to traumatic events among survivors, where 300,000 children and 500,000 adults were brutally massacred over a 100-day period.

The findings from the national Baseline Trauma Survey of 3,030 children aged 8-19 years, conducted by the UNICEF Trauma Programme and the Ministry of Rehabilitation one year after the genocide, showed that 95% of the children and adolescents from all 12 prefectures throughout the country witnessed some kind of violence during the war. In fact, 69% of them actually saw someone being injured or killed, and 78% heard people screaming for help while being injured and/or killed. More than half of the sample witnessed killings where the perpetrators used machetes (57.7%) or sticks (59.2%) to beat their victims to death.

Of the children interviewed, 56% had been bereaved of fathers, 46% of mothers and more than half of the sample had experienced the death of a sibling or other relative. Among the 79% of children who experienced death in their immediate family, more than one third witnessed the killing of their own parents or siblings. In addition, almost all the children saw dead bodies or body parts, and the majority of them reported that they had to hide for prolonged periods of time in the banana leaves or sorghum fields, surviving on insects, mud, and droplets of rainwater during the fighting. Many children also said that they had to hide under the corpses of their family members, classmates or friends in order to survive the massacres that occurred in their homes, schools and

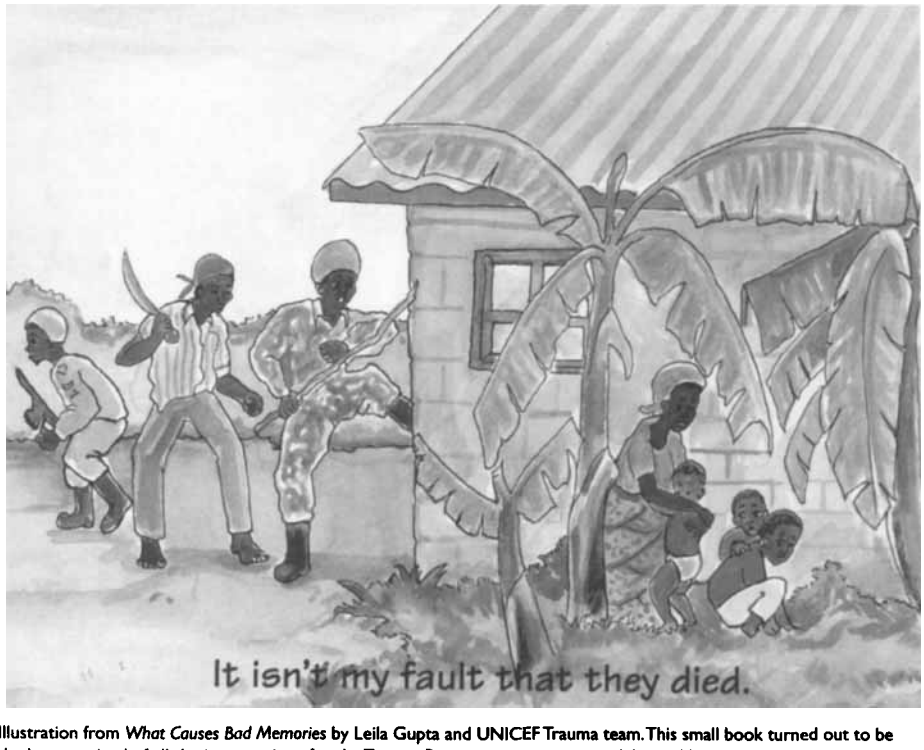

Illustration from *What Causes Bad Memories* by Leila Gupta and UNICEF Trauma team. This small book turned out to be the best received of all the interventions for the Trauma Recovery programme, widely used by teachers and caregivers alike. One of the unanticipated outcomes was that the version in the local language was read by the children to their less-literate parents and relatives, so that the book ended up being therapeutic for adults as well. © UNICEF

churches. More than one third of the children interviewed said that they saw other children participate in the killing or injuring of others, and 52% witnessed many people being killed at one time. Finally, almost all the children believed that they would die at some time during the genocide, and nearly two thirds of them were actually threatened with death.

TRAUMATIC STRESS & GRIEF REACTIONS

In general, the data from the Impact of Events Scale[11] used in the Follow-up Trauma Survey (conducted two years after the genocide on a subset of 327 of the children who had participated in the Baseline Trauma Survey), shows that the majority of Rwandan children continued to have intrusive images, thoughts and feelings more than 24 months after the fighting, despite their attempts not to think about it. In terms of avoidance symptoms related to the violence they witnessed, 70% of the children reported that they sometimes or often tried to avoid things that reminded them of the event. In addition, more than two thirds said they sometimes or often tried not to talk about it or think about it. The majority of the sample also reported increased physiological symptoms of arousal, including hyper-vigilance, anxiety, shaking or sweating when confronted with reminders of the traumatic event. Finally, 55% of the children said that they sometimes or often had difficulty concentrating, and 53 % continued to have trouble falling and/or staying asleep.

In terms of children's grief reactions following the genocide, the Follow-up Survey data showed that 84% of the respondents were bereaved as a result of the war. The Children's Grief Reactions Scale[12] was used to assess children's feelings about the deaths of those close to them. The respondents were asked to say how they were feeling now, at the time of the interview, about a loved one's death from the 1994 war; the three response categories were: often, sometimes and never. The majority of children reported that they sometimes or often ask themselves why their loved one had died, and 87% said they believed that nothing would ever be the same without their deceased family member. In addition, more than two thirds of the respondents reported that they often felt angry about the death of their family member, and 58% felt guilty because they had survived the genocide. Almost all the children experienced sadness on holidays, birthdays and anniversary dates of their family members' deaths, 71% said that they cried whenever they thought about their dead loved ones, and 88% said they tried not to show their sad feelings at school. Finally, 77% of the children reported that they felt there was little left to live for without their loved ones.

INTERVENTION STRATEGIES

The Trauma Recovery programme uses several community-based strategies. The 'training of trainers' strategy used by the trauma advisers in the 12 prefectures throughout the country ensures that local communities are provided with information on grief and trauma theory, culturally appropriate methods of expression, emotional support, and training on how to facilitate referrals to the outpatient clinic. The two or three day training emphasises identification of post-traumatic stress symptoms, normal grief reactions, and basic methods of trauma alleviation. The most widely-used expression techniques designed to help children confront their traumatic memories and, ultimately, to enable them to grieve the loss of their loved ones, include story-telling or talking about what happened during the genocide; drawing a picture of their worst memory; doing a role play or drama and changing the ending; singing; dancing; praying; and writing an essay about their life before, during and after the fighting.

Another intervention strategy used in 1995-97 involved a mass media campaign using the local radio station to broadcast informational messages in the local language about traumatic stress and grief reactions. Additional intervention strategies currently being implemented include the dissemination of educational information and research findings about the psychological effects of war on children, and participation in various seminars and workshops to raise awareness at the international level about the plight of Rwandan survivors following the genocide.

At present, the Trauma Recovery programme has trained 21,156 teachers, caregivers, social workers, community and religious leaders, health workers, and local associations through the trauma advisers in Rwanda. These trainees have assisted more than 200,000 children in schools, orphanages and communities. The National Trauma Center has provided outpatient therapeutic services to 1,146 severely traumatised and/or bereaved survivors aged four-65 years between June 1995 and March 1999. In addition, the Trauma programme has distributed 20,000 copies of the Kinyarwanda version of the children's booklet, *What Causes Bad Memories,* to teachers, caregivers, and community health workers throughout the country. This low-literacy booklet written by the author and the UNICEF Trauma staff, uses Rwandan child survivors' drawings and simple text to normalise traumatic stress symptoms and grief reactions related to children's exposures during the genocide. Finally, the data from the fourth year follow-up study conducted on a subset of child survivors interviewed in 1995 and 1996, is currently being analysed and the findings will be available to the public when the final report is completed. BC

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