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RWANDAN MENTAL HEALTH AND THE IMPLICATIONS OF WESTERN INVOLVEMENT

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Abstract

The purpose of this research was to explore factors associated with mental health service provision from the perspective of Rwandan professionals. Rwandan participants discussed how culture influenced the therapeutic needs and goals of citizens and how Western-trained professionals could support the development of local mental health services. An ethnographic study was conducted, which included semi-structured interviews with 10 Rwandan mental health professionals. The transcriptions were analyzed using a content analysis procedure to identify overarching themes from the data. Themes from the data included transitional stage, infrastructure development, emotional secrecy, multidisciplinary work, community integration, speaking outside of society and cultural awareness. These themes were compared and contrasted with the available literature. Similarities and differences were noted.

Keywords:

Rwanda; International Counselling; Cultural Psychology; Genocidal Trauma; Cross-Cultural Collaboration

Dedication

I would like to dedicate this thesis to my father, Lama Mugabo. I believe that I never would have written it if I had not grown up with a respect and pride for my own roots as a Rwandan. He has shown me how being an African-Canadian is special in that it ties me to a country that has so much communal strength and love for family and friends. He has reminded me that I am not alone in my unique identity as a Rwandan and to embrace all that it has to give me.

I sought out this research because I believe that the personal is political. My identity as an African living in Canada gives me the opportunity to share what that means with my colleagues in academia. Informing mental health researchers on how my country is thriving despite of such a horrific past makes it clear that our involvement as Westerners can continue to make a difference. To me, social justice research is about recognizing our impact as fellow citizens on the betterment of each other's lives. My father has shown me that we are all global citizens. The world is much smaller than we think and our reach can extend across many miles when recognize how connected we all are.

Acknowledgements

I would like to acknowledge all of those who helped me in each stage of the development of this thesis. The assistance I received from my family in Kigali, Rwanda was pivotal part of the data collection process. Specifically, I would like to first thank my cousin, Belice Mugakagame who introduced me to important people and helped orient me in a new, and at times bewildering, city that I have grown to love. Secondly, I would like to acknowledge the support that my father, Lama Mugabo, provided to my thesis. His guidance, whether or not it was introducing me to others, navigating me around Kigali or providing insight into the social and political context of my data, is immeasurable to my research. Thank you both of you for your assistance and support.

I would also like to acknowledge the participants who made the sample selection process so effective. Many of the participants went out of their way to introduce me to their colleagues who also fit the selection criteria. Each of these individuals showed me how important this research was to them, which has made me feel that I am contributing work that is valued by those it is intended to benefit. I am grateful for their support as well.

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seriously because they can become part of my reality as a researcher and a student if I work hard at it.

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Chapter 1: Introduction

International collaborations between Rwanda and professionals from the West are growing in strength and frequency, bringing together different cultures to offer skills and knowledge about mental health work. These partnerships are promising yet challenging. This research explores the nature of mental health services provided and relationships with Western-trained mental health professionals from the perspective of Rwandan mental health professionals. The purpose of this research is to explore factors associated with mental health service provision from Rwandan professionals, focusing on desired contributions of Western colleagues.

The psychological effects of the Rwandan genocide have persisted long after the political turmoil has passed. The genocide was the culmination of many decades of discrimination and propaganda that convinced citizens that the minority race, the Tutsi people were evil and not to be trusted (Kabeera & Sewpaul, 2008). In April of 1994, the majority race, the Hutu people, were called upon to exterminate the Tutsis and mass civil involvement in the killings lead to the death of a million people in 100 days (Kabeera, & Sewpaul, 2008). Because the violence was carried out between neighbours, colleagues and fellow citizens, the strength of community support and trust were obliterated (Mugabe, 2007).

Prevalence studies throughout Sub-Saharan Africa estimate post-traumatic stress disorder as affecting between 40 – 80% of those who have experienced or witnessed severe violence (Bolton, Neugebauer, & Ndogoni, 2002). Levels of depression dissipate, reaching norms somewhere between 8% and 5.8% (Bolton et al, 2002). The only prevalence study of depression in post-genocidal Rwanda was conducted in 1999,

yielding a result reflecting an above the norm prevalence rate of 15.5% (Bolton et al, 2002). Despite the fact that 10 years have passed since that study, Bolton suggested that his original numbers represented the chronic effect of the genocide on Rwandans and without widespread intervention, this rate was expected to persist (Bolton et al, 2002).

The literature suggests that this high rate of depression may continue because mental health services are far from pervasive. The reality of reaching all of those needing services is unsettling given that costs of service are beyond the resources of such an impoverished population (Bolton, et al., 2002). Mental health workers in Rwanda are beginning to borrow and modify Western methods to make them culturally appropriate and incorporate the practices into local service delivery to make services more available (de Jong, Scholte, Koeter, & Hart, 2000).

This research is concerned with Rwandan professionals' perspectives on mental health services. The researcher travelled to Africa, and the largest city of Rwanda, Kigali, to meet with local service providers and learn from their expertise working with local communities and Western-trained mental health professionals. These individuals agreed to meet and be interviewed on the topics of mental health, mental health services and working with Western-trained mental health professionals in the post-genocide era. Understanding how members of Rwandan cultures address mental health service is essential for Westerners who want to come and share their expertise with this country that is both challenged and empowered from a traumatic past.

Benefits of this Research

There is a lack of an interdisciplinary dialogue regarding how social, cultural and political factors contribute to the state of mental health services in Kigali. While a great

deal has been written to inform the academic community about these topics separately, it has not been integrated within a single study. This small East African nation has developed significantly since the genocide in 1994 and will continue to transform in the years to come. It is therefore important to explore these changes and synthesize their impact on the field of mental health service provision in general, and counselling in particular.

The goal of this study is to discuss the aspects of mental health that are deemed important by Rwandan professionals. This research provides evidence of how cultural context is inseparable from mental health and doing mental health work. Researchers may benefit from the results of this study, whether they are living in the West or in Rwanda. While the results are intended to contribute to Rwandan counsellors' understanding of how their clients envision the role of therapy in their lives, it will also demonstrate how their colleagues envision the role of mental health in the post-genocide reconstruction effort. In addition, researchers who engage on cross-cultural collaborative projects will become more informed about how culture influences their studies, and how Westerner-trained mental health professionals can contribute to the development of mental health services locally, in Rwanda.

Structure of this Thesis

In Chapter Two, a review is provided of the academic literature as it pertains to the development of the mental health field in Rwanda. In Chapter Three, an outline is provided of the methods that were used in the data collection process in Rwanda as well as the analysis that was conducted. Chapter Four presents the results that were generated

from the content analysis, and Chapter Five compares these results with the concepts presented in the literature.

Chapter 2: Literature Review

The literature on mental health services in post-genocide Rwanda is wide in scope and draws from a broad range of sources and topics. To begin, this chapter includes an overview of events that led to the genocide. A brief description of a concept of mental health follows. Current social conditions in Rwanda are briefly reviewed to highlight several major contemporary influences on mental health service development including poverty, HIV/AIDS, women's rights, the repatriation of refugees, as well as indigenous restorative justice practices. Central components of mental health service at the grassroots level, including the role of traditional healers, place of emotion in healing and community-based approaches to healing are described. In addition to grassroots efforts, the Rwandese government also operates mental health centres and offers training for local professionals to work specifically with children and families as well as more broadly with entire communities, and these are also described. Professionals from the Western world have provided a great deal of assistance to Rwandans in the post-genocide era, and the characteristics of partnerships that have been successful are presented before turning to the rationale for the present study.

Rwandan Genocide

Into the 19th century, Rwandans were a remarkably unified people (Mugabe, 2007). Groups were close to identical in terms of their religion, language, culture and geography, with only slight physical differences to distinguish between them (Thomas, 2008). All Rwandans spoke the same language, Kinyarwanda, which had a strong unifying effect on the different groups that included Tutsi, Hutu and Twa, or as in Kinyarwanda, 'Imbaga y'inyabutatu' (Mugabe, 2007). There was no history of violence

between the groups (Mutamba & Izabiliza, 2005), competition for resources or discrimination (Mugabe, 2007).

However, ethnic tensions emerged following the arrival of the Germans in the late 19th century who used the existing ethnic diversity to create social inequality (Thomas, 2008). The Tutsi, at 14% of the population, were granted educational privileges and given moderate ruling power over the Hutu, at 85%, and the Twa, at 1% (Kinzer, 2008). Resulting tensions were further exacerbated when Belgians took control of Rwanda as well as all other German colonies, proceeding World War 1 (Mugabe, 2007). The new colonial power implemented a nationwide identity card that classified each individual by ethnicity (Mugabe, 2007). An administrative reform policy was instituted in 1926 in order to dramatically change the governance structure (Mugabe, 2007). In place of equal representation by members of each of the three groups, the role of chief was passed on exclusively to a group of Tutsi families (Mugabe, 2007). This solidified the foundation for the resulting social conflict initiated by the inequalities introduced by the Germans.

Tutsi misuse of privilege led to a backlash in the form of a Hutu revolt during the country's rise to independence in 1959 (Thomas, 2008). This reversal in power was motivated by a Hutu manifesto based on prejudice and hatred which claimed that Tutsis were conspiring to appropriate all wealth and oppress the Hutus once again (Thomas, 2008). Mass-hysteria followed, and flourished during the late 1950's with the support of anti-Tutsi newspapers, radio and public rallies (Thomas, 2008) as well as finding its way into popular songs and school classes of the time (Mugabe, 2007). The violence that erupted led to the death of approximately 12 000 people (Mutamba & Izabiliza, 2005),

drove approximately 200 000 Tutsis out of the country into exile and created a groundswell of discrimination that lingered well into the 1990's (Thomas, 2008).

In the three decades after independence, Presidents Habyarimana and Kayibanda made it a political objective to continue discrimination against the Tutsi population to promote massive civilian support and involvement in the genocide. In the early 1990s, the Hutu government called for all Hutus to join the National Revolutionary Movement for Development (MRND) in which entire families including infants became registered (Veale & Dona, 2002). After the Hutu president was murdered in a plane bombing on April 6th 1994, Hutus accused the Tutsi rebel army, the Rwandan Patriotic Front, of breaking the Arusha peace accords and the genocide began (Dulian, 2004).

In the spring of 1994, radio broadcasts called Hutus to bear arms saying that disaster was imminent as Tutsis were mobilizing with the intent to overthrow the government (Thomas, 2008). Hutu citizens attacked their Tutsi neighbours in communities across the country (Dulian, 2004). Approximately 1 million people were killed and 2 million exiled (Pham, Weinstein, & Longman, 2004), including 75% of the Tutsi population (Veale & Dona, 2002) and Hutu moderates who tried to help their Tutsi neighbours survive the attacks. Those who survived were tortured, experienced property theft and destruction and became displaced or fled to become refugees in neighbouring countries (Pham et al., 2004). Although the exact number is unknown, an estimated 250 000 women were raped during the 100 days of the genocide (Mutamba & Izabiliza, 2005). Children were specifically seen as targets and 300 000 of them were killed (Veale & Dona, 2002). In addition, many children were orphaned by the genocide, leaving the

eldest to raise his/her siblings at a very young age. To this day, an estimated 40 000 children are said to be living in Child Headed Households (Veale & Dona, 2002).

Defining Mental Health

Mental health is not a culture-free concept. Each definition is influenced by the culture within which it is created. In any country, mental health is very difficult to define in a way that takes different cultural beliefs and values into account (Rodriguez, 2004). Multiple cultures exist together and while it is difficult to describe mental health without over generalizing, it is relevant to describe what characterizes Rwanda as a whole, and most importantly, to describe it in contrast with concepts in the North American literature.

In traditional Western psychology, personal development is autonomous and separate from other individuals' development (France, 2004). In contrast, Rwandan concepts of mental health are relational, and not individualistic, driven by a view of self that is primarily collateral-mutual instead of individualistic (France, Rodriguez & Hett, 2004). Rwandans prioritize the welfare of the collective over the pursuit of personal needs and wants (Rodriguez, 2004). Rwandan mental health is holistic, in contrast to a more compartmentalized approach "made up of discrete traits, abilities, values and motives, seeking separateness and independence from others (France, 2004, p. 17)". In essence, the goal of healing, from a Rwandan perspective, reflects an attempt to reestablish homeostasis within the individual and community by focusing attention on the balance of these intrapsychic and interpersonal as well as spiritual elements (Latzer, 2003), in contrast to a goal of increased self-knowledge and personal insight as an individual with a unique set of experiences and desires (Latzer, 2003). For the purpose of

this study, mental health is defined as a state of optimal functioning, including management of difficulties through the promotion of strengths. Interventions are considered to be "all actions that contribute to the human balance in relation to oneself and society" (Veale & Dona, 2002, p. 102).

Social Conditions

There have been many positive steps taken to improve social conditions in recent years. Several changes have addressed the local needs for service given the areas that were most impacted by the aftermath of the genocide. Factors that are influential on the development of responsive mental health services include poverty, HIV/AIDS, women's rights, return of refugees as well as indigenous restorative justice practices.

Poverty. Rwanda's reconstruction effort is characterized by both an immense struggle and undeniable hope. It is one of the poorest countries in the world with an average annual income per capita under $200 and 90% of the population living on less than $2 a day (United Nations Development Programme, 2009). Poverty is an enormous barrier to community development in that it keeps people preoccupied on survival. There is a saying in Kinyarwanda *udashinga ntabyina*, which translated, means "someone who is unable to stand up cannot dance" (Mugabe, 2007). Indeed, researchers believe that poverty alleviation is an essential element to preventing genocide in the future (UNDP, 2009). There are signs of positive change in the UNDP Human Development Report that noted a GDP growth rate of nearly 6% in 2000, in addition to growth of almost 10% since 1995 (Kabeera & Sewpaul, 2008). There was also a rapid 2% growth in the Human Development Index between 2000 and 2007, suggesting that the quality of life for Rwandans is improving (UNDP, 2009).

HIV/AIDS. HIV/AIDS has had a tremendous impact on the health of Rwandans. In 2005, 11.2% of the country was HIV positive (Mutamba & Izabiliza, 2005). Because many women were raped during the genocide, there was a rapid proliferation of HIV/AIDS and now a much higher prevalence among the female population than males (Mutamba & Izabiliza, 2005). Treatment of HIV/AIDS requires tremendous medical expense, putting an even greater burden on an impoverished nation (Mugabe, 2007). While the number of people being treated with antiretroviral drugs are unknown, poverty and cost of medication are making the situation challenging (Logan, 2006). Some non-government organizations provide access to treatment but there is not enough to meet demand (Logan, 2006).

Women. One of the most profound changes to emerge during the post-genocide reconstruction in Rwanda is the changing role of women. When the country was under colonial rule, it shifted from a moderately egalitarian culture into a patriarchal society (Mutamba & Izabiliza, 2005). Girls were denied education and women were denied salaried employment and land ownership (Mutamba & Izabiliza, 2005). After the genocide, the male population declined as many had been killed or left the country (Mutamba & Izabiliza, 2005). The government took a proactive role in promoting gender equality, and women began to take on more non-traditional roles in their families, such as managing finances and decision-making, in addition to having a more active role in the public sphere (Mutamba & Izabiliza, 2005). One of the most commendable advancements in gender equality is the level of female participation in government. Rwanda now has the highest level of women represented in the parliament in the world at 56% (Mutamba & Izabiliza, 2005).

However, gender inequality is still apparent. Literacy rates amongst women, at 47.8%, are still behind those of men at 58.1% (Mutamba & Izabiliza, 2005). Additionally, girls drop out of secondary school at nearly twice the rate of boys (Mutamba & Izabiliza, 2005). Woman abuse is a tremendous problem, and occurs mostly in the home making it difficult to address through law enforcement (Mutamba & Izabiliza, 2005).

Repatriation. There has been an enormous influx of repatriates in recent years. In 1997 alone, approximately 1 350 000 former Rwandans returned home, forming the largest repatriation movement in African history (Kabeera & Sewpaul, 2008). Many did not receive assistance from government for the few jobs available (Kabeera & Sewpaul, 2008). They brought with them languages and customs of their former nations of residence, mostly (90%) from the developing world (Kabeera & Sewpaul, 2008; UNDP, 2009). However, a strong minority who were in support of their return assisted their integration. Indeed, nearly 40% of the population supported letting all immigrants into the country regardless of the job situation (UNDP, 2009). This index of openness to outsiders was the fourth highest out of 52 countries surveyed for this study (UNDP, 2009).

Justice. An ancient form of serving justice through community efforts, known as Gacaca, has been used to accommodate the nearly 150, 000 prisoners facing trial after the genocide (Staub, 2004). This indigenous practice allows large numbers of people to be tried while giving families of their victims closure through attendance and participation in the process including a full account of what took place (Staub, 2004). Gacaca courts have

had a significant impact on the healing of Rwandese people in that it has given voice and validation to the emotions of the genocide survivors (Kabeera & Sewpaul, 2008).

Grassroots-Based Mental Health Service

Mental health, from a Rwandan perspective, is based on values and practices present within Rwandan cultures. Important culturally-specific aspects of mental health are reviewed in this section and include the role of traditional healers, place of emotions in expression and grassroots approaches to healing in communities.

Traditional Healers. Before colonization brought Christianity to the continent, many people living in Central and East Africa relied on their connection to spirits to explain their life circumstances (Janzen, 2001). From the perspectives of traditional healers, health and sickness were largely spiritual matters and at the whim of ancestral spirits known as abazimu in kinyarwanda (Veale & Dona, 2002). Physical and mental health problems were equally associated with exposure to toxic spiritual forces (Janzen, 2001), and with the growing presence of Western practitioners, both medical and religious, traditional healers moved underground (Chauvin, Mugaju & Comlavi, 1998). Many of those healers were killed during the genocide, and those who practice in Rwanda today do mostly herbalist work (Chauvin et. al, 1998).

Emotional Expression. The "non-expression of disagreement" is a deeply entrenched aspect of local Rwandan cultures (Veale & Dona, 2002). Historically, crowded living conditions and necessity of depending on others for survival provided practical motives for getting along with others by avoiding conflict. Colonization introduced competition and divisions along ethnic lines that served to create allegiances and allow people to distinguish between acceptable conduct within and between groups.

While the value of non-expression of disagreement was maintained within groups, it gave way, very dramatically, to competition and violence between groups, particularly during the time leading up to the genocide.

Open expression of emotion is typically discouraged, and notably rare in the coping styles of many Rwandans. For example, in the expression of trauma symptoms (Pham, Weinsten & Longman, 2004), high avoidance symptoms have been found amongst many Rwandan clients experiencing post-traumatic effects (Dyregrov, Gupta, Gjestad, & Mukanoheli, 2000). In a recent study close to half of participants being treated for post-traumatic stress reported several avoidance symptoms (Pham et. al, 2004).

Community-Based Approaches. The goals of grassroots mental health workers may not converge with the national government's vision of how to heal from the mass trauma of genocide. While the Rwandan government is under pressure to reinforce a sense of unity in their national identity and "giving voice to difference is too psychologically threatening" (Veale, 2000, p. 238), it is known that when differences are expressed and processed in a therapeutic context, healing can occur (Veale & Dona, 2002). For example, an extremely successful community-based group program operating out of the province of Byumba since 2006 has helped individuals overcome isolation and share with others what causes them pain (Richters, Dekker, & Scholte, 2008). Indeed, trauma-specific interventions show improved outcomes over more general mental health interventions (Staub et al., 2005). In addition, it is important that the beliefs that perpetuated genocide and alternatives are specifically addressed to in order to have an optimal healing effect (Staub et. al, 2005).

Community strengths. Sense of community plays a key role in mental health (Dyregrov et. al, 2000). When an entire community is crippled by trauma and grief, collective and individual healing capacity suffers (Dyregrov et. al, 2000). Cohesion is highly valued and culturally based. For instance, the last Saturday of every month is known as community service day called *Umuganda* (Kabeera & Sewpaul, 2008). Everyone, even the president, participates in an activity of their choice to strengthen their communities (Kabeera & Sewpaul, 2008).

Creative expression. In using creative means of expression, community members have come together as fellow Rwandans to heal from the past. Both perpetrators and survivors of the violence have been brought together to share stories through community theatre (Breed, 2006). Performers found participation in these activities to be "cleansing". They transformed their pain into a creative expression that deeply affected audiences and led to confessions during and after the shows (Breed, 2006). In this sense, organizations not mandated to do mental health work are capable of having an impact on psychological wellness.

Therapeutic communities. In addition to the healing benefits of community cohesion and creative means of expression, specific local therapeutic efforts that translated into English literally mean 'community as doctor' and emphasize democracy, non-directiveness and equality have made a difference (Richters et. al, 2008). Such therapeutic communities include local participants and helpers who live together and process what has happened to them within a supportive environment where each is encouraged to take greater ownership and increased participation as the process unfolds

(Richters et al, 2008). Indeed, community approaches are a necessity because it would take decades to offer individual counselling to all trauma survivors (Richters et. al, 2008).

These community activities illustrate how Rwandans at a grassroots level have begun to tell their stories and heal as communities from the tremendous pain and anguish of the genocide (Kabeera & Sewpaul, 2008). While Rwanda has suffered a horrific past, it is also comprised of communities that have made tremendous efforts to become a stronger and more unified nation that promotes healing and wellness among its citizens (Kabeera & Sewpaul, 2008).

Government-Based Mental Health Service

In addition to the grassroots mental health initiatives, a formal government system of mental health services is in place. Staff are trained locally, and provided with background and skills for individual level work, creative approaches to engagement and therapy as well as community-based mental health service provision techniques.

Mental Health Centers. Most counselling programs operate out of the Rwanda's capital, and largest city, Kigali (Richters, Dekker & Scholte, 2008). The Ministry of Health founded the Mental Health Coordination office in November 1994 (Chauvin, Mugaju & Comlavi, 1998). This office oversees operations of the Psycho-Social Center, formerly the National Trauma Center, as well as the Ndera Psychiatric Hospital (Chauvin et. al, 1998). The hospital deals with general psychiatric care while the Psycho-social Center specializes in healing from post-genocide trauma (Chauvin et. al, 1998). Since June 1995, the Centre has offered training for ministry based social workers and trauma counsellors (Chauvin et. al, 1998). It also offers community education, direct outpatient

service and holds a mandate to generate research on effects and healing from genocide-related trauma (Chauvin et. al, 1998).

Training of Professionals. Training is also done specifically for particular initiatives, such as the Trauma Recovery Program that targets children and families (Dyregrov, Gupta, Gjestad & Mukanoheli, 2000). The goal of the program is to educate those who work with children who have been deeply affected by war, regarding child development, the nature and treatment of trauma and helping skills (Dyregrov et. al, 2000). Specific helping skills are developed through training to identify symptoms and work through emotional expression arising from violence and loss (Dyregrov et. al, 2000). Culturally-based, creative art and story-telling activities are also reviewed (Summerfield, 1999). The program has been very successful in large part due to the specific training that professionals working in it have received (Chauvin et. al, 1998).

Community Level Training. Sociotherapy was developed in 2005 as a collaborative effort between the Byumba Diocese of the Episcopal Church and a group working with refugees in the Netherlands (Richters et. al, 2008). Developed by the Dutch psychiatrist Bierendbroodspot, this form of counselling, has been adapted to be culturally-sensitive to a Rwandan context, including recognition of differences in mental health practices and issues as well as sensitivity to the safety needs of war survivors (Richters et. al, 2008). Training the service providers within the program has included both theoretical and practice components within the community where the work is done. Those who have been reached by this program go far beyond local parishes, due to the inclusive mandate that made it accessible regardless of ethnicity or religion (Richters et. al, 2008). Participants included widowed women, orphans, adolescents and males who

have been released from jail (Richters et. al, 2008). The program has been nationally recognized, and funding dedicated for expansion within Rwanda to the city of Nyamata. It has also been adopted in other settings, such as Nyangezi, Congo (Richters et. al, 2008).

International Partnerships

Professionals from all over the world have mobilized to offer psychological assistance in Rwanda at unprecedented levels (Summerfield, 1999). Psychologists from the West have offered assistance for the development of functionality (Bolton & Tang, 2002) and frequency measures (de Jong et. al, 2000) for diagnostic and epidemiological purposes in mental health efforts with Rwandan populations. Additionally, they have directly helped Rwandans work through post-genocide trauma by providing service within therapeutic intervention programs (Staub et. al, 2005). In this section successes achieved through partnerships for mental health service are described, focusing on the highly successful sociotherapy model including some characteristics of that partnership that contributed to its success, and concluding with a more general summary of principles from the literature associated with successful partnerships between Rwandans and Western-trained mental health professionals.

Sociotherapy. The sociotherapy model employed in Rwanda shared several common elements with Western-based approaches to mental health service that have been highly effective at meeting local need within this small country halfway around the world. The goals as articulated by the Diocese in Byumba include stress reduction, restoration of a sense of dignity, promotion of social safety and stability into the future (Richters et. al, 2008). It was recognized that the genocide left many citizens in a constant

state of alertness, behaving in an aimless or aggressive fashion (Richters et. al, 2008), and consistently with symptoms of depression or post-traumatic stress (American Psychiatric Association, 1994).

The characteristics and skills that group facilitators needed to be effective in Rwanda were comparable to those of effective counsellors in the West. Beginning as an effective observer in tune with how people deal with personal tension and disagreements between group members, successful facilitators additionally possessed high levels of emotional stability, trustworthiness, empathy and communication skills (Richters et. al, 2008). These characteristics and abilities were all seen as necessary by Rwandans to do this work effectively in Rwanda (Richters et. al, 2008).

In order to reach mutual understanding about mental health interventions across cultures, it is necessary to have face-to-face meetings in the setting where the work is to take place. This allows the helpers to introduce themselves and learn about the community, in order to gain entry into the network between service providers and become more aware and connected to the local residents (Pham, et. al, 2004). A good fit between local culture and therapy approach is crucial (Pham, Weinsten & Longman, 2004), as evidenced by the success of the sociotherapy program in Byumba. In that case, the Dutch consulting team dedicated a month to field preparation before the program began to talk to a pastor of the Diocese and discuss what psychological support was needed (Richters et. al, 2008).

Characteristics of Successful Partnerships

Several principles can be gleaned from the literature about contributions to successful cross-cultural partnerships for mental health between Rwandans and

professionals from the West. These include responsibility for action, recognition of community as expert, openness to funding local initiatives and training and evaluation contributions.

Responsibility to act. In the wake of genocide, post-traumatic stress can ravage war-torn countries acting like a hidden epidemic that depletes the collective ability to function and rebuild (Summerfield, 1999). As UNICEF has said about the situation in Rwanda, 'time does not heal trauma' (Summerfield, 1999, p. 1451). It is clear that proactive efforts from many professionals of various fields are needed over time for Rwanda to continue its recovery (Summerfield, 1999). Mental health services are needed to help Rwandan society thrive, and powerful nations are obligated to support the psychosocial development of Rwandan citizens. For example, the Convention of the Rights of the Child that took place in Rwanda addressed the role that other nations should play in supporting children in the wake of political disaster (Veale & Dona, 2002). It was also noted that psychological health was more than just a form of self-actualization that may or may not be reached, it was a human right that could not be ignored by those that are in a position to address it.

Community as expert. Cross-cultural mental health collaboration efforts should take into consideration the ongoing debate about how the relationship formed in relation to the legacy of imperialism (Grey, 2005). The belittlement of indigenous knowledge dates back to colonial discourse where Europeans viewed their rationale as superiorly complex to that of their colonized (Summerfield, 1999). Present-day relationships must be sensitive to the potential for a pejorative dynamic to develop and become professional imperialism (Grey, 2005). It is therefore important that these partnerships are not based

on a didactic dissemination of knowledge, but instead transformation of expertise and resources in a way that suits the needs and cultural beliefs of the local residents (Askeland & Bradley, 2007). Adaptation is necessary for mental health workers to meet the needs of a different cultural context (Ejaz, 1991). An 'indigenization' process of modification for adaptation to the other culture is necessary (Nimmagadda & Cowger, 1999). As responsible as the developed world is to share expertise with the developing world, it is equally responsible for making sure any contributions are culturally appropriate.

Funding local initiatives. In order for Western-trained mental health practitioners to work effectively in Rwanda, knowledge of local needs and history is important (Summerfield, 1999). An exploratory trip is necessary in order to build and strengthen relationships, learn about the community and most importantly, avoid undermining current efforts of local indigenous workers (Summerfield, 1999). It is crucial to know when residents simply need only material resources to help them continue their own initiatives, and in those circumstances to offer funding to pre-existing efforts instead of developing new projects (Summerfield, 1999). When new projects are wanted, true collaboration can lead to the sort of program that speaks for the needs and desires of the intended beneficiaries, drawing on their knowledge base and experiences to determine the best course of action (Summerfield, 1999).

Training and evaluation contributions. Successful cross-cultural partnerships for mental health efforts in Rwanda are formed not because those who come to help are the only ones with expertise to offer, but rather that they have specific knowledge and resources that can be useful in locally managed and delivered services. There is ample

research to suggest that cross-cultural projects are needed to advance the psychological well-being among residents. Indeed, professionals from less affluent countries, like Rwanda, struggle to develop mental health programs independent of the help of more prosperous nations (Askeland & Bradley, 2007). This is due to the demands placed on their limited finances and resources available within Rwanda, which is only beginning to acquire that information (Askeland & Bradley, 2007). When new or existing programs provide evidence of success in training, impact and certification, they are validated and more visible for national and international attention, which invites new opportunities for resources (Richters et. al, 2008).

Rationale for the Present Study

Although trauma may be experienced as an individual psychological reality, there are social, cultural and somatic aspects that are significant consequences of the personal and interpersonal effects of the genocide in Rwanda (Dyregrov et. al, 2000). Indeed, trauma-related distress is more than a psychological issue; it is a normal response to extreme devastation (Summerfield, 1999). This has led many Rwandans to question why they've been pathologized into needing treatment (Summerfield, 1999). A more relevant conceptualization may be to focus on strength and capacity building within individuals and communities who want support that is realistic, given their experience. Indeed, attention to the psychological health of refugees, and in the present study, repatriates is relatively recent, starting in the early 1980s (Summerfield, 1999) yet crucial for the development of respectful and helpful efforts to health from past trauma and promote future wellness among individuals and communities in Rwanda.

The literature suggests that mental heath is a serious challenge for many individuals and communities in present-day Rwanda, 15 years after the genocide. Although social conditions have improved, high levels of poverty continue to exist, HIV/AIDS remains a major health threat, and many citizens who fled the genocide have returned to grim economic prospects but a solid revival of indigenous health practices to promote community healing from the conflicts of the past. Women are highly represented within the country's government and are well positioned to lead the country into the future. Their work is complemented by grassroots efforts of citizens to promote healing through community cohesion and creative expression. Government initiated mental health efforts have provided institutional and community-based support and training and international partnerships with Western trained mental health professionals have led to the development of novel approaches as well as much-needed resources for local efforts.

There has been no research to date on the perspectives of mental health professionals in Rwanda who have lived through the genocide and worked with helping professionals from the West regarding their perceptions of mental health services in Rwanda. The present exploratory study offers some information to a broader audience of helping professionals about characteristics of mental health service provision in post-genocide Rwanda from the perspectives of Rwandan service providers themselves.

Chapter 3: Methodology

The purpose of this research is to explore factors associated with mental health service provision from Rwandan professionals' perspectives. In this chapter, a description of the research process is presented, including background on ethnographic research, the approach taken in the study, and followed by a description of the recruitment process, participants, data collection and analysis procedures followed.

Ethnographic Research

Creswell (2009) has defined ethnographic research as "qualitative research procedures for describing, analyzing, and interpreting a culture-sharing group's shared patterns of behavior, beliefs and language that develop over time." The present study was ethnography in that it investigated the culturally specific experiences and norms of Rwandan mental health professionals. Ethnography was chosen because it was the most appropriate way to investigate those norms through immersion in the culture. Data were collected during a two-month visit by the researcher to Rwanda.

The history of ethnography dates back to the 1920's, when cultural anthropologists developed the method. By the 1990's, dilemmas developed within the field based on two issues, including representation and legitimacy. To address these concerns, researchers now provide details of their analysis as well as personal reflections on the entire process to promote transparency, and to compare the results of the analysis to existing literature from a variety of sources to promote credibility.

There are three types of ethnographies. Critical ethnography is used to challenge the status quo and advocate on behalf of oppressed social groups. The goal is to engage in a dialogue with participants to unearth the motivation behind political acts that create

social inequality. Case study looks at a bounded system, either by time or place, and includes data from various sources to generate a rich description of that case. The case is related back to the 'larger picture' by illustrating how specifically, it exemplifies cases in the broader context. The present study was a realistic ethnography. The goal of realistic ethnography is to present the results from third person perspective. All personal reflections were limited to the designated section of the results chapter. Many details were presented through the use of multiple quotations from participants. What made this style different from critical ethnography is that the researcher played a more distant role in how the results were presented and interpreted.

The key characteristics of an ethnography were apparent in the study. First, the study investigated shared qualities of culture within a group, taking into account the diverse life circumstances that Rwandan professionals face regarding mental health needs. The study was the product of weeks of fieldwork in Kigali, Rwanda and participants' perspectives. An important part of the data analysis was that the researcher took a reflexive role.

The steps for conducting an ethnography were followed. Initially, it included identifying the purpose of the study and how it was achieved through the chosen design. Ethics and community approval to conduct the study were obtained prior to seeking access to the target population for data collection. Data was collected from several participants while the researcher was immersed in the culture. Finally the data were analyzed and interpreted and a report written.

Several measures were taken in to promote high quality of the research. The researcher identified the group studied, Rwandan mental health workers, and the cultural

context, post-genocidal Rwanda. As well, details from the interviews were provided in the results chapter and the author has supplied her own personal reflections on the research process. This was done in order to make her viewpoint transparent so that readers can get an accurate understanding of the extent of her personal bias presented in the research. Finally, by referring to mental health service in the context of post-genocidal reconstruction, the data were consistently connected to the study's purpose.

Recruitment

A convenience sample of mental health professionals in Kigali of Rwandan descent who were willing to discuss the nature of mental health services after the genocide was used. Potential participants contacted the researcher directly, via a local telephone number, in response to advertisements (see Appendix A) that were placed in mental health agencies and distributed by individuals known to the researcher who were involved in health care and social justice research. Potential participants were provided with informed consent and given a letter of information (see Appendix B) to keep for their own reference. A small honorarium ($5 CDN equivalent) was offered.

A snowballing technique was used to solicit further contacts. Participants were asked to share information about the study and the researcher's contact information with others who fit the selection criteria for participation. This technique was chosen because it was known to facilitate development of trust among potential participants who are unknown to the researcher (Patten, 1997). It proved to be very successful as personal contacts lead to six potential participants and snowballing led to eight potential participants. In fact, participants were generally quite open and willing to advertise for

the study. Even the one participant who declined participation advertised it to several contacts who were interested.

It was anticipated that most interviews would be conducted in English, as it was widely spoken in Rwanda. However, some participants indicated a preference for conducting the interview in Kinyarwanda or French. Those participants were offered interpreter services so the interview could be conducted in their language.

Participants

A total of 14 potential participants contacted the researcher, and 13 agreed to participate. However, only 12 interviews were completed because one individual could not complete the interview due to an ongoing illness during the time of the researcher's visit to Rwanda. During the final few interviews, there were no novel responses, and it became clear that saturation of the data was reached after ten interviews. While three participants elected to be interviewed by the researcher and interpreter, translation services into English could only be obtained for one interview and therefore the other two were not included in the analysis.

Among the ten participants for whom English transcripts were available, 6 were male and 4 female. Among the ten, 4 were psychologists, 3 were professors, 2 were counsellors and one was a psychiatrist. A total of 5 were employed in non-governmental organizations, 3 at universities, 1 at a counselling centre and 1 in a hospital. Nine of the 10 had previous experience working with traveling Western professionals and the remaining participant had well-established professional ties and anticipated a face-to-face visit in the clear future. All were academically trained as counsellors, nurses, psychologists and psychiatrists, and all were significantly connected to how life is

experienced at the community level and spoke at length about this topic during the interviews. As a result, the title of community leader was applied as they could knowledgably articulate the mental health values, needs and goals from an indigenous perspective. None of the participants accepted the honorarium, as they considered it inappropriate to receive financial incentive as a participant for research. In their cultural context, it was sufficient to communicate appreciation for their involvement with a verbal thank-you.

Data Collection

Semi-structured interviews were conducted (see Appendix C). Data collection took place during the researcher's stay in Rwanda. Interviews were conducted during a trip from June to August of 2009. Data collection involved meeting in person with participants and conducting interviews that took between 30 – 90 minutes. The location of the interview was chosen by participants to take place in private office space where they worked, in order to accommodate their comfort level and daily demands.

Data Analysis

After each interview was completed, the recording was transcribed verbatim. Two of the interviews were excluded from data analysis because they were conducted in Kinyarwanda and translation services could not be obtained due to a logistical error. However, the data set includes one interview that was translated from Kinyarwanda to English while the researcher was in Rwanda.

The interview transcripts were analyzed to identify emerging themes using the method of content analysis outlined by Creswell (2009). The first step was to organize and prepare the data for analysis. This involved verbatim transcriptions of each interview.

The second step was to read through all of the transcripts to get a sense of the general meaning conveyed. The third step was for the data to be coded. To do this all "meaning units" were highlighted, including phrases, sentences and passages that were viewed by the researcher as significant and related to the purpose of the study. These meaning units were labeled with a one or two-word code (see Appendix D). In the fourth step, the codes were used to identify themes. Then the codes were reviewed with their corresponding meaning unit, and combined. The fifth step was the grouping of codes into themes (see Appendix E). Finally, in step six the data were interpreted. In Chapter 4, the themes are presented and in Chapter 5 the themes are interpreted via a comparison to the available literature reviewed in Chapter 2.

Chapter 4: Results

Seven themes emerged from the interview data that were collected by the researcher from ten mental health professionals in Rwanda. These themes included Transitional Stage, Infrastructure Development, Emotional Secrecy, Multidisciplinary Work, Community Integration, Speaking Outside of Society and Cultural Awareness. In this chapter each theme is described and illustrated by several quotes from the interviews. In addition, to promote trustworthiness an account of the researcher's personal reflections about the research topic, process and meaning of results is included in this chapter.

Themes from Interview Data

The following is a brief summary of the themes. Transitional Stage referred to Rwanda as going through a modernization process and that it had an effect on how mental health services were evolving. Infrastructure Development referred to how formal mental health services were becoming more widespread due to the contributions of partners from the international community, but major gaps in coverage existed. Emotional Secrecy referred to the relatively common experience of emotional non-disclosure among many Rwandans, and men in particular. Multidisciplinary Work referred to how the mental health services required collaboration across several related helping professions, including medically-trained individuals, those with formal counselling training as well as indigenous healers. Community Integration referred to the importance of mutual support among neighbors and local expertise in mental health that was in place prior to the genocide. Speaking Outside of Society referred to the need to challenge practices and expectations in order to reach people in need and provide effective mental health services. Cultural Awareness referred to the dynamics in mental

health services that were unique to this time in Rwanda's history and influenced the work of mental health professionals.

Transitional Stage

Transitional Stage referred to Rwanda in a process of modernization and the impact it had on mental health services. Since the genocide Rwanda has been transitioning from a less developed to a more modern country and along with the associated opportunities of economic growth, more emphasis was placed on the need for formal mental health services and increasing demand for those services. Partnerships based on mutual respect with those from the international community were also changing from being seen as a charity case in the past to equal partners in the present.

As the Vision 2020 goals set out by the national government reflected, the economic and social service capacity of the country has witnessed a recent period of growth (Kinzer, 2008).

> *They are investing here. There are several countries that are heavily invested, here in Rwanda, including North America, US and Canada and um and other nationalities, Nigeria, you know, Kenya. We have two Kenyan companies, Kenyan banks here in Rwanda, and many more other nationalities are investing here. So the economy of Rwanda is actually booming compared to other African countries. So, uh Rwanda is becoming a uh, uh, a home for all other groups of people, which is beautiful, you know.* (Participant 6)

The economic changes have led to increased opportunities. However, new challenges have emerged for people because of the stress of developing such rapidly expanding social programs. As a result, the need for mental health services is increasing.

> *People are having stress, they are traumatized. They are having cancers because they are hiding whatever inside them. They are having so many different diseases because they don't talk out their problems. So, should we get more counsellors? Then they will be taught and they will know about it, yeah. These professional counsellors are the ones I mean, eh?*

> *Because mostly in Rwanda, we want to, to grow. To be rich, to have this, to be modern, Vision 2020 but deep inside people are frustrated. They are eating many different problems and they fall sick and they die.* (Participant 7)

Africa used to be perceived as a go-to place for charitable donations that were not necessarily needed or wanted. However this is changing, and the relationships with those from the international community who come to help are more often based on respect.

> *Do you know sometime Western, they are not, for example, but now it is not happening. For example, they have had a lot of computer who are not used. And they said because Africa is, is poor, they send those computers because they have nowhere to put, yeah. That is not collaboration. Yeah, you give to people what they have asked for. Yeah, and you interact and discuss with respect. Yeah.* (Participant 9)

The partnerships that have emerged in the field of mental health more closely resemble true collaborations and are quite different from prior experiences with those from the West.

> *It is through solidarity and respect. Competence, they are in two ways. Now we are changing our minds. Because before it was like white men is the one who is supposed to give us everything. But now, it is like a partner. It is why I say solidarity.* (Participant 9)

Infrastructure Development

Infrastructure Development referred to how formal mental health services were becoming more widespread due to the contributions of partners from the international community, but major gaps in coverage existed. These gaps were due to high levels of poverty and lack of financial means to access formal services, as well as rural access in communities that were too far from major centres where the existing services were located and low levels of formal training in mental health for new service providers.

While international organizations operating in the country were providing service, resources for Rwandan administered services were in relatively short supply.

> *Who, there are many, many international organization, who have mental health programs here in Rwanda. And if they locate some, some counsellors, some psychologists, they have to deal directly with the community. They have the program, the community. They have service in their office where they see people for counselling, for therapeutic programs, psychotherapeutic programs.* (Participant 5)

The extreme poverty experienced by many across the country clearly exacerbated the mental health challenges that people faced. It was suggested that employment opportunities could make a difference in the lives of people who struggled with mental health concerns.

> *You know, it's not only problems of trauma but also extreme poverty. You see, and if I give an example, those women who are here are, at the beginning they are really, very very depressed. But that income generation projects they produce something you see, they smile, they are good, they produce something. They not need to use anti-depression to help them to deal with the depression because they work, they produce. They, they that income generation project give them value.* (Participant 3)

Although medical insurance (Mituelle) was available and covered mental health service in some cases, those who needed service but couldn't afford insurance were still able to be seen.

> *and if you can't make pay uh the amount, personal amount and uh if if you have a certificate to the local governor to prove you are very poor you can't pay the insurance will pay (writes down) So it's not a problem to to to see a counsellor for payment. I think it's a problem of mind* (Participant 1)

Accessibility was a significant barrier to counselling. There were considerably fewer counselling resources in the outlying areas compared to towns and cities. Aside from animateurs, local indigenous helpers, there were no formal mental health services for clients to access on a regular basis in many locations. Those in rural villages were the most underserved.

> *But, in the rural area, I don't know if they have any chance to go in the rural area. People are not, since they are running, they become, how do you call it, mad. Yeah, really losing their mind. They not go to see counsellor.* (Participant 9)

Counselling training was needed. There was a lack of training available at the university level for mental health workers, and most training programs were professional programs for psychologists, psychiatrists or psychiatric nurses. There was a need to train mental health workers to provide service after a short training program in order to provide a level of service that would meet the needs.

> *I think if we continue that relationship with universities, it will allow Rwandans to broaden their education experience. I hope I can make sense to bring in culture. I think that personally it will be beneficial to continue working with them to build on my professional skills. So you understand, I'd like to advance beyond my current level in order to better work alongside highly educated professionals.* (Participant 2)

Emotional Secrecy

Emotional Secrecy referred to the relatively common experience of emotional non-disclosure among many Rwandans and among men in particular. There were important safety reasons for keeping emotions to self, but to others in the communities and those providing mental health services, the indications were clear. Every year at the time of the genocide, behaviors suggesting high levels of stress and need for mental health services rose sharply.

Emotional expression was seen as an admission of a problem and could make them vulnerable in the eyes of others. Given the traumatic past that many had experienced, the fear of repercussions associated with being seen as weak were severe.

> *And uh, in private they, people think that when you are in private place, nobody know know what is happening. It is, it is kept secret, mmm. And mainly the enemies, don't see, don't. When you are in private place,*

> *enemies, people who don't like you don't know, don't know see you crying, don't not see your weakness.* (Participant 8)

For many Rwandans, and men in particular, keeping emotional experiences private meant having real strength.

> *No, no. Among women, it's more tolerable* (to cry in public). *Men have to be strong, like a real man.* (Interviewer: laughs) (Participant 2)

The gender differences in emotional expression were highlighted by a well-known saying in Kinyarwanda translated into English.

> *Because, you know, I don't know how I can express that uh, in English but there, there is a ways to say in Rwanda, men cry and when they cry it going inside ... They, when they cry but the l'arme, what is it in English, the l'arme, the tear go inside it's a ways to say in Rwanda, he will cry but it don't show because they think they are power.* (Participant 3)

Symptoms of emotional difficulties manifested in a variety of behaviors, and those, instead of the trauma itself, became a focus of mental health attention.

> *I feel like helping her but I don't know how to begin with her problem, eh. Who ever has a problem fix. Her minds are disturbed and taking care of themselves becomes uh, they don't remember to take care of themselves. Maybe they thought that they, uh they have nothing to live for, to live for, so sometimes, maybe food is scarce, let's say for example, and after they say, "Why should I eat?" They don't think they, they they should shouldn't forget, you see. Or maybe one can come extra clean. I know one person who has no people, they just give him some, some things. He will rest until maybe, he will rest after finishing the whole. He will overwash himself, overwash the clothes until that one piece of soap is over, that's when he will stop.* (Participant 7)

Although the emotional content of a verbal message was apparent through body language or physical expression, the connection to emotionality for many clients of mental health services was protected.

> *Well, it is, it is encouraged but not easy to know because people pretend to be having no problems. They can, they cover up the problems, so it is not easy to know. It is not easy to know. Unless, when you are observant and*

> *you learn how to get the non-verbals, you will know there is a problem.* (Participant 7)

Every year in the months that coincided with the beginning and end of the genocide in 1994, mental health services were in particularly high demand.

> *Mmm, you see here in Rwanda, we we make many many problems, different problems. But the main problem is uh, is trauma. And the trauma which is characterized by different emotions and um, some. Mainly in the period of mourning, April of every year, here in Rwanda, we meet many many many many problems of emotional problems. So, in that period, counsellors have very very hard work.* (Participant 5)

Multidisciplinary Work

Multidisciplinary Work referred to how the mental health services required collaboration across several related helping professions including medically-trained individuals, those with formal counselling training as well as indigenous healers. Many Rwandans approached religious leaders or physicians for their mental health problems, and expected intervention in line with what those helpers provided. However, the use of counselling, in contrast to prayer and ceremony or a medical procedure, was surrounded by much more stigma.

There was a strong connection within Rwandan cultures between spirit and mind, and understanding that illness in one was related to illness in the other realm.

> *Mental health, yeah it's all things who have a weight on our minds, yeah, a weight. A weight meaning uh for a better, a better mental health, we feel okay happy. We have good, good, uh good feelings. But when we are sick, we feel bad with negative feelings, with bad feelings. And even here in spirituality, it's it's similar, it's very, it's very similar because all over our feelings are around our our mind, you see, around the spirit, around our mind.* (Participant 4)

Often, a physician was the first point of contact among those who seek formal mental health service. As a result, many expected medical interventions instead of counselling support.

> *They don't think anything about counselling because they come to see the doctor, a physician. Nothing about counselling so they learn more about counselling when they receive counselling, okay.* (Participant 3)

Depending on how the mental health problem was defined, it was considered and treated as a spiritual matter or a matter of emotional well-being. There were strong beliefs within Rwandan cultures about the importance and role of spirits in illness and service providers needed to be sensitive to those beliefs and act accordingly.

> *I remember, when I was working in neuropsychiatric hospital, I receive in my office uh one young boy. He was a solider and all member of family was died and he was with, he, he survive with two uh, member of family? No, uh one uh brother and one sister. And before Dad died, before Dad, the member of family died, they gave the whole responsibility. You are the head of the family. And during genocide he, after genocide he is going in army and he feel sad because he don't know what happen to sister and to uh brother. When he told me he say, when I find an opportunity to see my sister and my brother and to respond to they, their wish, I will never have mental problems. And we work together as a team, we give her a weekend to stay in the family and he feel better. Because you see, 'cause it's related to how he think how he belief, you see? And those who believe to god, they think mental trouble is uh bad spirit and they call that demon, I don't know how to call?* (Participant 3)

The stigma that surrounded mental health and mental illness was starting to lift through the presence of health professionals and religious leaders coming forward to talk about mental illness as equivalent to a physical or spiritual injury.

> *Okay, now, I think psychologist and physicians are trying to break this kind of, you know traditional diagnosis or religious diagnosis by showing people that, "Hey, mental illness is a health problem, like having a broken leg or uh, a stomach problem that needs to be taken care of by medical professionals including psychiatrists and, and psychologists."* (Participant 6)

Community Integration

Community Integration referred to the importance of bringing together communities for support, as had existed prior to the events leading to the genocide, by recognizing the needs of people in the community before they became very problematic for families and therefore responsive to the local expertise of the church and animateurs. The genocide marked a dramatic shift in the nature of local informal mental health services. Before the tremendous loss of life, relocations and disconnections with family, friends and community, other people known to residents provided support at times of difficulty. After the genocide, dynamics within the community were characterized by alienation and judgment. Trust was damaged and professionals became more commonly sought out.

> *Traditionally what happened, if you had problems, you'd go to your aunt, you'd go to your uncle, you'd go to your neighbour and then talk things over. So people were counsellors of one another. But after the genocide, their were no family members left to run to. Neighbours became untrusted because these are the same neighbours who killed the family, your family members. So you don't trust your neighbour anymore. So psychologists became the way out of pain.* (Participant 6)

A powerful indicator of mental health in many communities was the way in which one handled their household affairs. Those who were struggling were more likely to be identified as in need of help if their children were struggling.

> *A woman who has lost her handle on her children's upbringing, a woman who misbehaves, a woman who gives a poor image of her children, people can say she is ill, take her to Ndera. So, whereas a woman who takes care of her home, the Rwandan culture welcomes her, regardless of what she does with her children. If someone says something about her behaviour, people will quickly come to her defense, say, Well, look at her children, they're well behaved, they're well brought up, she's fine.* (Participant 2)

The Christian church also met mental health needs. It gave parishioners the opportunity to share common experiences and pray together.

> *Catholic church they have, the program from community to national level. The community they have what they call uh, family communities, what they call um, in kinyarwanda unknown/phrase. Family communites where in the village, the members of Catholic church, they meet one week to exchange, to pray. And after the, the praying, they change their life, their problems. So I think it's it's the structure they, they put there, but I think it help, it helps somehow in mental health because even if they, they don't have uh some training in mental health, in counselling, you know what?* (Participant 5)

The role of community integration of counselling skills was done on behalf of voluntary workers called animateurs. These were unpaid individuals who received minimal training to reach out to those in their community who were in need of a good listener and did not have access to a counsellor. Their role was especially important tin rural areas where access to therapeutic services was not feasible. There were approximately 11 000 animateurs throughout Rwanda.

Speaking Outside of Society

Speaking Outside of Society referred to the need to challenge practices and expectations in order to reach people in need and provide effective mental health services. These challenges came in the form of promoting emotional awareness and expression among clients who had not found relief through either religious healing or the services of medical doctors. Mental health workers from outside of Rwanda were seen as assets in that they were more often seen by residents as neutral in their ethnic affiliation and by extension, the approaches they used to help.

Emotional awareness and expression were seen as an effective means to achieving good mental health.

> *You express it, so that you, you get help. If you don't express it, people will might think that is no problem when it is eating you inside and you are dying slowly. Yeah, it's good to express it.* (Participant 7)

The efforts of religious healers did not consistently meet the mental health needs of residents, and participants expressed concern about the personal blame on clients that followed a lack of response to healing efforts as well as the need for intervention by authorities to prevent negative outcomes.

> *I don't say that god cannot heal people, he can, but he can when he want to do it. But you cannot take all sick people and put them in a place and you don't give medicine and expect them to be cured, no. So it happened that some people believed they can just cure, like that and I think the government had to intervene.* (Participant 10)

There was a misperception about what mental health services were for many who sought them. Service providers struggled to clarify expectations with clients about what they could expect to happen and how the outcomes would be achieved in counselling.

> *They think that you will give advice, like guideline. If they have problem of getting sleep, they think that you will tell them, "Do this, this and this and this." Mmm. They don't understand very well this concept, mmm. They think that you give, to give guideline, advice.* (Participant 8)

The place of Westerners in the provision of mental health services was positive. Among some communities, mistrust of fellow Rwandans was high and a professional who was not Rwandan was seen as more neutral given past ethnic conflict.

> *And what they bring, those people, what I had forget, in Rwanda we are still in this kind of conflict, Hutu and Tutsi. And for me, I like with, to act with people of outside, because they have distance. They have no judgment. Sometime when they have, people have to think, when you have problem you have to ask sometime. When it is Rwandese, those conflict, conflict, it can influence the relation and how to see a problem. But when these somebody of outside, he, he, he is not too much influenced by what has happened here.* (Participant 8)

Cultural Awareness

Cultural Awareness referred to the dynamics in mental health services that were unique to the time in Rwanda's history and influenced the work of mental health professionals. Working in the mental health profession required a comprehensive understanding of the cultural beliefs of Rwandans. They frequently referred to the importance of adapting theoretical approaches to their cultural context. In fact, one of the goals of Rwandan mental health workers was to develop theories and practices that were a blend of Rwandan and Western cultures.

> *Rwandan culture traits have a significant role. We need to be able to understand our culture so that we can defend it and put it in a context that works with our patient's beliefs.* (Participant 2)

Cultural awareness also meant understanding the range of values that one could expect. After the genocide, the repatriation of over a million people returning from the Diaspora made Rwanda a multicultural society. Those who grew up abroad brought their values and cultural behaviours to create a range of cultures within Rwanda.

> *Rwanda nowadays is a mixture of Rwandan culture and many other cultures because of where people lived during their lives when they were refugees.* (Participant 7)

Participants viewed Western trained professionals playing an important role in adapting to the cultural diversity in Rwanda. Because multiculturalism has evolved more slowly and steadily as a part of modern life in the West, those from the West were seen to be in a better position to understand this social phenomenon.

> *I think for example, they are experience from several cultures about trauma. Mmm. So not just the West, but all over the world. Okay. And I think in the West, there may be such field of transculture.* (Participant 3)

Summary

It was clear that life in Rwanda was characterized by change in many ways. Modernization has changed how culture and mental health influenced one another. Residents and mental health service providers were coming together, reconnecting as neighbours and collaborating across various helping professions. Citizens were beginning to view emotional expressiveness as helpful and are reaching out to access the mental health services available. Most importantly, Rwandan mental health professionals were acting as catalysts of change by taking on a role as social critics, envisioning new possibilities for their clients. Rwandan culture was far from one-dimensional and there was a growing openness to welcome newcomers whether it was as permanent residents or collaborators in the mental health field who have come from other parts of the world.

Personal Reflections

I first became interested in doing research in Rwanda when my father told me that he was moving from Vancouver, BC to Kigali. He had been working as a city planner for several years and he wanted to offer his valuable professional skills to his home country after living in Canada for the past 26 years. Talking about Rwanda, development and social justice had been a common occurrence during our times together. He was certainly the first person that made me reflect on the type of global citizen I could be. Shortly after I told him I had been admitted to graduate school, he asked me "if you were to come to Rwanda and were going to do a research project in counselling psychology, what would it look like." Envisioning those possibilities seemed to light a fire in me and I felt that I had found a topic that ignited passion in me to see it through the lengthy process of writing a thesis.

The Participant Solicitation Process

Shortly after I arrived, I began soliciting participants for the study. I did not want to wait because I had no idea how long it would take me to conduct enough interviews to reach the saturation point for the study. I began the process by contacting organizations where potential participants could be employed and asked if I could send posters advertising the study. Participants made contacts for me and those who were interested called me to find out more. This information usually broke the ice and I think it also made them feel as though they were helping out a mutual acquaintance, which I appreciated.

Then I met and talked about my stay in Rwanda. These individuals were almost always inquisitive as to how I came to do my thesis research here, how my studies had progressed and how I was enjoying my visit thus far. It was nice to be reminded that as much as I was intrigued by them, they were equally intrigued by me. Indeed, I had come from so far away and it made me feel like the 'exotic other.' Of all the minority statuses I have embraced in my life, my cultural identity as a Canadian has never been one of them until now.

After we had become acquainted with one another, I introduced the study. I gave them a copy of the informed consent form, re-iterated its contents and elaborated on what I hoped this research would achieve. I tried to convey that I was interested in learning their stories as professionals in the Rwandan mental health field. I emphasized the fact that I believe that cultural beliefs influence how mental health is conceptualized by a society and that I wanted to understand this link in order to share these insights with other Westerners. It was important to me that potential participants be aware of my motives so

that they feel as though they are contributing to research that they believe in. I believe this is at the essence of how an ethnography is successfully conducted. It was my goal to become an ally in the effort to share their strengths and concerns about Rwandan mental health with the Western academic community. In the end, I think it created an open, trusting rapport in which people felt at ease to explore their experiences at length during the interview process.

Adapting to a Different Conception of Time

Setting up meetings with Rwandan participants took a certain strategy that was all part of my cross-cultural adaptation process. I was expecting to set up as many interviews in the future as possible. I thought that I could gauge my tenacity as a researcher by how booked in advance my calendar would become. When I re-evaluate how concerted of an effort I put out, I believe I definitely put a lot of hard work into the data process and yet, my schedule looked nothing like I anticipated. My schedule was rarely filled out further in advance than a few days and I rarely knew how hectic my week would be when Monday morning came around.

You see, there is such a thing called Africa time. As a first generation Canadian, I figured it referred to the lack of punctuality that many people of African descent exhibit when meeting up to various social gatherings. Indeed, when I was in Rwanda, people were generally less punctual than in Canada, but I also discovered the fortuitous flip side to this phenomenon. When I asked to initially meet with potential participants, people typically said sure and suggested a day that was one or two days in advance. Sometimes if I called on a Thursday, they'd ask to meet next week, but generally it wasn't too far in the future that they'd make the time to meet me. I think this is the upside to Africa time

because in this case as well, time is a fluid concept. The day, or the remainder of the week, is not set in stone and if they are interested in meeting someone new, they'll make time and have faith that things will get done. Indeed, in Rwanda the workdays are long and things get done, just not in the linear way that Canadians strive to by constricting their schedule. Perhaps this is why only one person I approached to be part of the study said 'I'd like to, but I don't have the time.'

Willingness to Participation

In fact, I was quite surprised that so few people declined to participate in this study. Because I am a novice researcher and I've never been to Rwanda before, my expectations were shaped heavily by the literature review I did. I was expecting a certain degree of resistance and skepticism as a Westerner coming to study an 'exotic' and 'troubled' land such as Rwanda. But that was far from my impression of my initial interactions with participants. I think several things worked in my favor. First of all, being a half-Black individual with an African name lessened the sense that I was an 'other'. Secondly, I was often introduced to potential participants via my advertisement by a family member, increasing a sense of trust between us.

However, both of these things are unique to my particular situation and it would be unlikely to be experienced by other researchers. Something I also realized is that Rwandans are uniquely optimistic individuals. It takes an incredible amount of strength for a nation of people to recover some sort of semblance of a normal social environment. This type of strength isn't garnered through resentment, but instead, it's cultivated through hope. I think that the tendency of Rwandan mental health workers is to approach visiting Westerners with a renewed sense of possibility for the future. Rebuilding a war-

ravaged impoverished nation is impossible without a considerable amount of assistance, if only financial, from international non-governmental organizations and social groups. I knew that Rwandan mental health professionals had a series of respectful and fruitful collaborative experiences with Westerners because they projected those well-meaning intentions to me as a researcher at the onset of our interactions together.

When I began the data collection process, I was very curious as to how the central role of religion in Rwandan culture would factor into the participant solicitation process. Indeed, upon meeting new people, I was often asked my religious affiliation. Because I consider myself to be more spiritual than religious, my response often elicited shocked and confused looks in others. It was not uncommon for people to fervently point out that my life could be filled with such joy and peace if I read the bible and accepted Jesus Christ into my heart. I did not interpret this as aggressive proselytizing; I felt as though this was their way to help me discover something that they felt had enriched their lives. Considering that most people I met were in the country during the genocide and experienced trauma to some degree, the human capacity to transcend misery by focusing on one's faith would be impossible to overlook.

Openness to Cultural Diversity

When I was meeting potential participants and getting to know them before beginning the informed consent process, a few did in fact ask me my religious affiliation. I gave an honest answer that I didn't follow one particular religion and my answer did not seem to hinder any of my research objectives. When I first met potential participants, I worked at establishing a certain level of trust in order to ensure that the interview could be as open and honest as possible. I never felt my answer disappointed them in any way

or that it created distance between us because I am a 'non-believer'. I think this shows a high level of acceptance to diversity and that establishing a strong rapport with Rwandans isn't contingent upon similarities in anything else but work ethics.

I also believe that this was reflected in the tone of the participants' responses. When clients spoke of the importance that religion plays in how Rwandans conceptualize their mental health, they tended to present this as a statement instead of a proclamation. In general, they spoke in the third party and didn't give any indication that one should make religion a priority in order to meet his/her wellness needs. I rarely had any indication of how they personally interpreted the connection between religious devotion and mental health. In being able to distinguish personal views from the beliefs of their clients helped me to feel optimistic about the future of cross-cultural collaborations. Again, there wasn't a reliance on similarities between the Rwandan and the Westerners religious beliefs in order to find compatible goals in order to develop research projects and interventions together. During the interviews I felt that both the participant and I were focusing on Rwandan society instead of being fixated on our different cultural identities.

Chapter 5: Discussion

This study began with a visit to Rwanda where data collection took place. Ten participants were interviewed and their responses were transcribed and analyzed using a qualitative content analysis procedure. Seven themes emerged from the analysis including Transitional Stage, Infrastructure Development, Emotional Secrecy, Multidisciplinary Work, Community Integration, Speaking Outside of Society and Cultural Awareness. Transitional Stage described the changing political and social dynamics in Rwanda fifteen years after the genocide. Infrastructure Development examined how services were accessed by citizens and how professionals in the mental health field were educated. Emotional Secrecy highlighted the pervasive social norm of emotional stoicism in regards to self-expression. Multidisciplinary Work addressed the collaborative nature of relationships between different helping professions in Rwanda as well as international colleagues. Community Integration focused on how community strength and social cohesion had a direct influence on the mental health of Rwandans. Speaking Outside of Society revealed the critical perspective that mental health workers took in order to envision more adaptive means of achieving therapeutic goals. Cultural Awareness recognized the need for counselling practice to embrace indigenous Rwandan norms as well as integrate the many dimensions of culture in this post-genocidal society.

Throughout Chapter 5, a comparison and contrast will take place between the themes from the data and the literature. This will highlight the contributions that both the data and the literature have made regarding key issues within each of the themes.

Transitional Stage

Westerners came to build professional partnerships with Rwandans because the country was transitioning into a nation attractive to helpers who wanted to contribute to the developmental effort. This was apparent in both the literature and indicated by participants. The liberal, business friendly economic policies and low-corruption rates also made Rwanda an attractive investment opportunity (Kinzer, 2008). The goal of the national government was to make it appealing to foreign involvement and there was a great deal of receptivity to collaborations in general, and collaborative projects in the mental health field in particular (Kinzer, 2008).

The progressive changes that both male and female roles were undergoing, as well as the need to evolve even further, were described. While there was still an adherence to more traditional image of genders, the transition in many cases had begun and was expected to continue (Mutamba & Izabiliza, 2005). Furthermore, a large part of this modernization was because of the repatriation of many Rwandans living in exile (Kabeera & Sewpaul, 2008). This was mentioned briefly in the literature and discussed frequently by participants.

A difference between the literature and data was on the topic of North-South relations and likelihood that they would continue to be problematic and imperialistic as in the past. While the literature warned of this potential, participants were far more positive in their assessment of these dynamics and reported that relationships have changed for the better. Participants highlighted how they felt that traveling professionals acted as partners who grew from one another, and both had the interests of Rwanda's development at heart. This difference may have been because the literature did not

mention Rwanda specifically but rather about post-colonial dynamics in general. While Rwanda was developing, the government's goal is decrease their reliance on foreign aid and more on building a sustainable infrastructure development. Indeed, this accounted for why Rwandans expected Westerners to treat them as partners instead of recipients of charity.

Infrastructure Development

The literature was consistent with the way in which participants discussed infrastructure development. While both sources highlighted the facilities initially established after the genocide, the participants were able to draw attention to the lack of services in rural areas and the need for more professional development opportunities.

Chauvin et. al (1998) stated that the main goal of counselling was to address the trauma needs of Rwandans after the genocide. This was also the case for the participants who frequently mentioned the priority of their role in helping clients deal with the long-term effects of the genocide. This was an interesting consistency because the research regarding the development of counselling services took place eleven years ago, shortly after these offices opened. It appeared as though Rwandan mental health workers were faced with the same issues from their clientele due to the longstanding effects of trauma resulting from the genocide.

There was also consistency between literature and data regarding the goals for development of mental health research and services. The literature did acknowledge the importance of getting a coherent picture of what was needed in Rwanda before beginning projects (Summerfield, 1999). This was of particular importance to participants who mentioned that what was given and what was needed did not coincide.

Participants brought up two future goals that were not present in the literature. The first one was the inaccessibility to counselling in rural areas. Because most of the counselling work was done by animateurs, the help available is effective for basic listening and support but lacked assessment and treatment capacities. The second issue that participants described was regarding the training of counsellors. There seemed to be too few schools that educated Rwandans to carry out the counselling work on the scale that the country needed. Participants envisioned that the role of Westerners would be to come and teach courses in order to assist in the training of more counsellors in Rwanda. They saw traveling mental health professionals as providing opportunities to learn from their experience and provide service, given the lack of trained therapists.

Role of Expression

The role of emotional non-expression was a prominent theme in the data and it was also apparent in the literature. Participants addressed the significance of emotional stoicism as a prevalent social norm and a barrier to reaching therapeutic goals.

While the importance of opening up and finding a therapeutic release for emotional distress was discussed in both the literature and the data (Veale & Dona, 2002), there were some discrepancies. Participants discussed the fact that emotional suppression was a far bigger priority for men than for women It was seen as tied to a man's gender identity to be strong and therefore, stoic. Participants described that suppression of such extreme emotional distress such as the genocide trauma had powerful effects fifteen years later. A great deal of psychologically induced physical pain and reoccurring traumatic symptoms tended to reoccur.

Multidisciplinary Work

Both the participants and the literature described the interconnected role of mental health work and other social services. There was reference in the literature to the collaborative nature of cross-cultural projects. The data also described how mental health involved an integration of medical health care, spiritual wellness and religious intervention. The success of church programs such as the sociotherapy project in Byumba was consistent with the data (Richters et. al, 2008). They provided as example of what participants said about how people relied on the church to heal their emotional problems in a manner that was also accomplished through counselling. Indeed, clinicians learned from church members about how to promote mental wellness of clients. They also provided guidance about how to foster trust and empathy with clients.

Participants talked far more about the therapeutic capacity of traditional spiritual healers than was apparent in the literature. Traditional healers worked alongside counsellors. Clients sometimes found that they required spiritual intervention while in therapy.

It was clear from the interviews that mental health and health care were very interconnected. Counselling at certain facilities was covered by medical insurance. Furthermore, counsellors at the government run facility, Psychosocial Centre, were psychiatric nurses so they could provide counsellling with an understanding of the client's overall health needs. While there was literature on the health concerns amongst the Rwandan population, there was less attention to the link between medical care and mental health.

Role of Community

The important role that participants saw between the community and the mental health of citizens was consistent with the emphasis it was given in the literature. While the literature emphasized grassroots justice as a means to strengthen communities, both sources discussed similar concepts.

Both the literature and the data referenced the pivotal role that communities played after genocide. Dyregrov et. al (2000) talked about how community strength was a determinant of gaining a sense of normalcy after war. Participants talked about how trust eroded as the ethnic conflict escaladed, which lead up to and culminated in the genocide. Whereas community was the initial contact sought out in times of distress, mental health services were becoming more needed.

Integrating therapy at a community level seemed to be an effective way in which to overcome reluctance towards mental health services. Both participants and the literature referred to this concept. Work at the community level was done by animateurs, who sought out needy local residents, and for such individuals formal mental health services were not compelling.

The literature also drew a connection between the role of gacaca in emotional healing that participants did not mention. The ability to face perpetrators, gain information about the events surrounding the killings of their loved ones and see them brought to justice had a therapeutic potential that participants did not identify (Kabeera & Sewpaul, 2008).

Looking Outside of Society

Compared to the literature, the data offered a new perspective on how Rwandan mental health providers worked with their clientele. While the literature did not directly reference how workers critique unhelpful behaviors, this theme was consistent with what researchers had to say about mental health in developing countries. In particular, Summerfield stated that it was natural for views of mental health to change in modernizing countries in response to international collaborations (1999). The data were giving a more specific example of how mental health workers stand near the front of social change by introducing clients to new ways in which to view their lives.

The way in which the therapeutic alliance was constructed was consistent with the type of counselling that Westerners provided as training for Rwandan mental health workers. The sociotherapy program was an example of how successful therapeutic interventions complied with a generally Westernized notion of counselling (Richters et. al, 2008). Indeed, this was echoed in the participant's comments on the importance of developing mutual trust and respect for the client. They saw that their ability to provide healing rested upon their ability to develop a trusting therapeutic alliance.

Cultural Adaptability

The importance of cultural understanding in mental health was seen as important by participants and identified within the literature. While both sources recognized this important concept, the literature focused solely on adaptability while the data introduced the importance of multiculturalism and diversity in the post-genocidal society.

The importance of mental health work being adapted to suit the cultural values of Rwanda was presented in both the interviews and the literature. Nimmagadda & Cowger

referred to this as the indigenization process whereby theoretical work originating in the West needed to be transformed to be relevant to the people it as trying to help (1999). Participants made it clear that they hoped future research projects would focus on adapting ideas from the West to fit with Rwandan culture.

The literature did not speak to the multicultural society that Rwanda has become. Because of mass repatriation, there was no single dominant culture. Finding a single set of cultural values from which to work was therefore not possible, and therefore an attitude of cultural receptivity was important. Participants suggested that Western mental health workers who work in multicultural nations could be helpful to Rwandans in this regard.

Summary

Overall, there was a great deal of consistency between the literature and the themes that emerged from participant interviews however, some differences were apparent and are summarized here. Participants focused on the current needs of the field in contrast to the literature that highlighted initial steps taken to establish services to meet the immediate post-genocidal therapeutic needs. Participants also described the role that stocism played in confounding therapeutic interventions as well as the importance of sensitizing the public to being more expressive. The data highlighted the important connection between mental health and spiritual leadership, which was not described in the literature. International partnerships that were true collaborations existed, according to participants but not commonly cited in the literature. Reference to the multicultural nature of Rwandan society was emphasized more so by participants than the literature. In contrast to the literature, participants in the study described the role of mental health

workers in providing new ways of coping in a changing, multicultural context. In the literature there was greater emphasis on community health in relation to mental health than was expressed by participants in the study.

Limitations

The study was not without limitations in relation to sampling and interpretation. The method of recruitment may have led to participation of individuals with similar perspectives. In particular, there was consistency among participants regarding positive experiences with Westerners in the past. Because participants were often colleagues of one another, they may have been commenting on shared experiences.

The purpose was to identify salient aspects of Rwandan mental health from the perspectives of mental health service providers in Rwanda. Given the size of the topic and number of participants, an exhaustive account of all important aspects was not possible. Although the participants were asked to identify the aspects they considered important, the researcher also interpreted their words, and the results would be different from how another researcher may collect and interpret the data.

Finally, it is important to recognize that this is an account of the development thus far in the mental health field, and as a result it is specific to this particular point in time. As the post-genocidal reconstruction effort continues, future changes will occur at a political, social, economic and cultural level. This will have implications on the mental health community due to the interconnected nature of this field. As a result, it would be beneficial to return to conduct similar studies at a later date, in order to track the progress of this burgeoning and rapidly evolving aspect of Rwandan society.

Implications for Western Counsellors

Clinicians in the West will also benefit from recognizing the interconnectedness of culture, social development and mental health. As many Western countries are becoming more ethnically diverse, masters and doctoral programs are ensuring that graduates can meet this need by offering courses in multicultural counselling. Ethnographic studies, such as this one, can provide an illuminating example of the powerful role that culture plays in mental health needs of the client. Therefore, this research offers a rich description of the many factors that clinicians may consider in order to develop an effective rapport with bicultural and immigrant clients.

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Appendix A: Recruitment Flyer

Helping People in Your Community.

Adults aged 18 – 75 who have lived in Rwanda for at least 5 years.

I am interesting in learning about how people help others in their community to deal with emotional issues.

If you would like more information or to participate in the study, please contact Adija Mugabo at 078 506 9355.

You will be given 2600 Rwandan Francs in appreciation for your assistance with the study.

Thank you

Appendix B: Letter of Information

Rwandan Mental Health and the Implications of Western Involvement

You are invited to participate in a research study about helping behaviours in Rwanda at the community level.

This project is being done by Adija Mugabo and Dr Jason Brown. Adija Mugabo is a Masters student at University of Western Ontario in London, Ontario in Canada and Dr. Jason Brown is her supervisor. Until August 26th, you can reach Adija while she is staying in Kigali. Afterwards, you can reach her at XXX-XXXX. If you prefer email, you can reach her at XXX@XXX. If you wish to speak to Dr. Jason Brown, you can call or email them at XXX-XXXX, XXX@XXX.

I am studying counselling psychology and I am interested in learning about projects happening in Canada that relate to mental health. I would like to talk to you about your experiences and ideas and provide you with a chance to share your thoughts.

I would like to more about what Rwandan culture says about what it means to have a healthy mind. I would like to ask you about what sorts of emotions people should have to make them strong and how families and communities can help each other during difficult times. Also, if you have ever done any projects with people from Canada, the United States or Europe, I would like to ask you about those experiences as well.

If you agree, we will talk for 60 – 90 minutes at a private room at the Psycho Social Mental Health Clinic in Kigali. If you would feel more comfortable talking in French or Kinyarwanda, I can ask someone to join us to translate our conversation. She will also keep everything we say private.

If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published. All information collected for the study will be kept confidential.

Although it is unlikely, there is a small possibility that unpleasant memories may arise. I will never ask you to describe anything specific, so if you don't want to talk about anything unpleasant, you don't have to

You may choose to participate or not. It is up to you. If you choose to talk with me you can change your mind at any time. You can refuse to answer any question or you can end our conversation at any time. Your decision about participating will not affect you in any way.

If you would like more information about anything please feel free to ask me before we start or during our talk.

If you agree, we will audio record our discussion so that we can remember what we talked about. These recordings will be written out on my computer, in a file that no one else will be able to read except me. This information will be kept in a locked cabinet in a locked office by the researchers, and destroyed after five years. At the end of conversation, I would like to give you 2600 Rwandan Francs. This is my way of thanking you for the knowledge you will be sharing with me for this study.

When the project is over, you can get a copy of what we learned and our suggestions if you like. You can email me and I can send you a copy of my results next summer.

If you have any questions about the conduct of this study or your rights as a research participant you may contact the Manager, Office of Research Ethics, The University of Western Ontario at 519-661-3036 or ethics@uwo.ca.

We hope that you will agree to help us by sharing your ideas with us.

This letter is yours to keep for future reference.

Appendix C: Interview Questions

Part I: Survey of Pre-existing Mental Health Services

1. What do Rwandans anticipate from the work done in the mental health field?
2. Do people facing emotional distress consider seeing a counsellor? If the cost weren't an issue, would more people be open to going?
3. Are other services sought out in order to meet their psychological wellness needs?

Part II: Rwandan Society and Mental Health

1. Is it ideal for an individual to have a high or low degree of emotional expressiveness?
2. What role does the mind-body connection, spirituality or religion play in having healthy thoughts and feelings?
3. What social norms dictate how psychologically healthy men and women are portrayed in society?

Part III: Description of Professional Relationships (for applicable participants*)

1. How were you approached by the foreign group or individual? *
2. What insights, knowledge or skills do you find valuable to this day? *
3. What would you like to learn from a Western mental health professional?
4. What role would you like foreigners to have when collaborating with them?

Appendix D: Passages by Code

Basic Resources

Because people lack uh their shelter, shelter, lack food, lack medicines, everything. They, they, firstly people need to, to be supported on, with the co-ordination of psychosocial.

Because they work, they produce. They, they that income generation project give them value.

And when they are able to provide funds for income generation projects, it's helpful in Rwanda. You know, it's not only problems of trauma but also extreme poverty.

Sometime they think that we'll give social support, material support.

They were working to, to give psychological support for people living with HIV/AIDS. They used to go in group counselling but every, everyday women were dying and they started to to be involved in fundraising, in advocacy to say that people are dying here.

It's not easy because inside her, does whatever expensive, I can't afford, can't afford my, my money is limited, little money, money, money, money. So money has haunted her.

"We need financial support." So financial support to help them to attend school is one of those services. They need clothing, they need housing.

But that income generation projects they produce something you see, they smile, they are good, they produce something. They not need to use anti-depression to help them to deal with the depression because they work, they produce. They, they that income generation project give them value.

Career Development

I think it is not like in other countries, countries where you you you have a program of counselling in university

I think if we continue that relationship with universities, it will allow Rwandans to broaden their education experience. I hope I can make sense to bring in culture. I think that personally it will be beneficial to continue working with them to build on my professional skills. So you understand, I'd like to advance beyond my current level in order to better work alongside highly educated professionals.

Counsellors would come, professional counsellors, and places, offices for counselling.

In mental health. Um, I want them to uh, to bring um to do more research in mental health, within the Rwandan context, the African context. And I also want them to bring their willingness to learn from the Rwandans, knowing that they are also some people

who have some knowledge. You know, there is something that we can learn from the Rwandans that can actually help us do a better job here.

Changing Dynamics

It is through solidarity and respect. Competence, they are in two ways. Now we are changing our minds. Because before it was like white men is the one who is supposed to give us everything. But now, it is like a partner. It is why I say solidarity.

Now we are changing our minds. Because before it was like white men is the one who is supposed to give us everything. But now, it is like a partner. It is why I say solidarity.

to Rwanda university, we have professor in anthropology and before starting research like yours, he is getting the course from a Rwandan anthropologist, yeah. As a professor, because he have the competencies, and as a Rwandan, because of his culture.

Yeah. Let me give you an example. We have, because we are collaborating with Western Ontario in the university where you come from. Yeah, Western Ontario. And we get a student who come for clinical practice, he was supervised by our nurses. And the credits he gets, they have been validated

in his school, yeah. That is two ways. But before we are used to go to study in West, yeah. But now, things they are changing. Even now in near neighbour countries, they come to study and we go outside. Now it is in two ways.

Charity Disrespectful

Do you know sometime Western, they are not, for example, but now it is not happening. For example, they have had a lot of computer who are not used. And they said because Africa is, is poor, they send those computers because they have nowhere to put, yeah. That is not collaboration. Yeah, you give to people what they have asked for. Yeah, and you interact and discuss with respect. Yeah.

Church Involvement

Mental health, yeah it's all things who have a weight on our minds, yeah, a weight. A weight meaning uh for a better, a better mental health, we feel okay happy. We have good, good, uh good feelings. But when we are sick, we feel bad with negative feelings, with bad feelings. And even here in spirituality, it's it's similar, it's very, it's very similar because all over our feelings are around our our mind, you see, around the spirit, around our mind.
Me I can say that the religions have the program of counselling without knowing that.

It's now, after the genocide, we have a lot of churches

And when they are suffering, for example they are with stomachache, uh related to a kind of uh hypochondriac uh symptoms, they think that all, all, all of this is physic, is physical. Yeah, demons. And then they have to pray all the night and starving in order to help, to to calm from those demons. Yeah, and sometime it can help as a kind of psychotherapy.

And then when you reach there, you'll find that your company with Jesus. And you, you will become a friend of Jesus.

All over our feelings are around our our mind, you see, around the spirit, around our mind. Uh the reason why some of the givers in mental health are preists or nuns you see. Sometimes we meet them and discuss with them, for for asking them about, about mental health but we gain, we gain uh from them. Yeah, yeah, we gain from them and they gain from us. Then, we are two kind of givers, yeah, who who are very close.

I don't say that god cannot heal people, he can, but he can when he want to do it.

They have to be connected to Him in able to be to be happy. To have children, to have job, to have wife, to have family. in uh, in traditional religion, Rwandan think that to be connected to his to to to what you call, mental health. To heal his business, to heal happiness.

Church Support

And, in practical, sometime they meet sometime for example, for the Catholic church, they meet in the community, one, once once by week, in the, on the village.

For example, for the children who is orphan, they go. They do few money but, everybody go in church

Maybe they can disclose this, uh some, some uh problems to, to their church leaders, church leaders, eh? One doesn't have a family leader and, maybe church leaders,

Family communites where in the village, the members of Catholic church, they meet one week to exchange, to pray. And after the, the praying, they change their life, their problems. So I think it's it's the structure they, they put there, but I think it help, it helps somehow in mental health

Community Therapists

Suffering. Yeah, but, uh, do you see, in the community, for example, here at Handicap Internationale, we are using community approach.

Uh, in, in, in community you have counsellors, you have counsellors, but you have also call Animateurs de Sante, meaning uh health uh, health care givers.

Cost Accessibility

Cost is an issue. Um, there is insurance, health insurance or they call it medical insurance here. Um, but you have to pay some fees to buy it. It's not very expensive but you'll find a lot of people who actually don't afford it. So because of that, you are not able to get the mental health services that you need, you know.

Even if you don't have money, sometimes the ministry can pay for you, but no one goes back because he has no money.

And if you can't make pay uh the amount, personal amount and uh if if you have a certificate to the local governer to prove you are very poor you can't pay the insurance will pay (writes down) So it's not a problem to to to see a counsellor for payment. I think it's a problem of mind

Expression Begun

All I know is that many patients who come to the consultation were in the beginning women and children and at the end, this, after 10 years, now we start to receive men.

Before it was like, a quiet person was respected, but now with the genocide, with the sensitizing of emotional expression, it's considered better to express oneself than to keep quiet.

Because mostly in Rwanda, we want to, to grow. To be rich, to have this, to be modern, Vision 2020 but deep inside people are frustrated. They are eating many different problems and they fall sick and they die. Should they get counsellors to grow up with them, this Vision 2020 and grow in with counsellors in Vision 2020? People can manage to reach there, but without counselling, I need counsellors 'cause I need counselling to some people

Expression Change

To to to to be very strong against events and to to to improve them, the culture says.

But each person, whether Rwandese or not, I think when it has come to the point you just burst.

Yeah, yeah. Ah, what else? Uh, our culture considers men as somebody strong, physically, psychologically, etcetera. But it's not true. We think that me, as a psychologist, I think that women are more strong than men, are stronger than men, psychologically speaking.

I don't understand very well. Because if I'm sad I cry and if I'm happy I laugh, but not the other way around. Yeah, sometimes those beliefs, you see people, they, it is inhibition of their emotion

You express it, so that you, you get help. If you don't express it, people will might think that is no problem when it is eating you inside and you are dying slowly. Yeah, it's good to express it.

For those persons in suffering. Because in our culture, it is said that we don't have to to to let our emotion go out. We have to to to internalize, to internalize and then when a counsellor is in, when a person suffering is in touch with a counsellor then the person can let it go out, his emotional distress. And then it's, it's a way of getting better in his, his mind.

Facing Emotions

I don't say that god cannot heal people, he can, but he can when he want to do it. But you cannot take all sick people and put them in a place and you don't give medicine and expect them to be cured, no. So it happened that some people believed they can just cure, like that and I think the government had to intervene.

If you have a problem normally I have to explain my emotions and you have problem of our culture.

Facilities Hidden

I don't see a counsellor they would go to. RCT/Ruhuca functions mainly in April, so I don't know what they do the rest of the, the month of the year.

But for trauma problems for service of counselling, you can find somewhere you you you you get service free.

Foreign Investment

They are investing here. There are several countries that are heavily invested, here in Rwanda, including North America, US and Canada and um and other nationalities, Nigeria, you know, Kenya. We have two Kenyan companies, Kenyan banks here in Rwanda, and many more other nationalities are investing here. So the economy of Rwanda is actually booming compared to other African countries. So, uh Rwanda is becoming a uh, uh, a home for all other groups of people, which is beautiful, you know.

To say, World Bankers giving Rwanda money. And so many others people are bringing in money to help people.

And therefore, the government opened its borders to other nationalities to come in and the government pays them to work here. Others just came in just to help. Uh they offer their own services, they offer even their own money, you know. There is also another trend in the sense that um because of Rwanda's liberal uh policies, uh other nationalities find it easy to come here and do business here.

Genocidal Breakdown

Other countries have not had their family members you know killed, like Rwanda has.

You can do uh counselling therapy without social support um and you won't feel well. Sometimes you need support from the surroundings, yeah.

It mean that you are not, you are, you are not yourself. You have lost many things sensible, do you see? And then uh, people begin to avoid you, to avoid.

The community resources ... that is what, that's how Rwandese people was used to deal with the stress before genocide.

Now sometimes after genocide you have problems with neighbours you have problems with in uhhh your job I think it's not personal problem

And normally we are not used to to do as um, people come for counselling. We try to use community resources, culture um resources.

And uh, especially, professionally mental, mental health workers because they realize that people trust, to neighbours, to environment.

Traditionally what happened, if you had problems, you'd go to your aunt, you'd go to your uncle, you'd go to your neighbour and then talk things over. So people were counsellors of one another. But after the genocide, their were no family members left to run to. Neighbours became untrusted because these are the same neighbours who killed the family, your family members. So you don't trust your neighbour anymore. So psychologists became the way out of pain.

Because when you have a problem, you go to a person who is part of your family, to you go to your close friend.

(Interviewer: So why do you thing people go to see a counsellor, if –) When every other kind of support has failed, yeah.

Genocidal Trauma

And uh, in private they, people think that when you are in private place, nobody know know what is happening. It is, it is kept secret, mmm. And mainly the enemies, don't see, don't. When you are in private place, enemies, people who don't like you don't know, don't know see you crying, don't not see your weakness.

But I realized that Rwandan culture, people would rather die with their own problems. Speaking it out is not easy.

Survivors of the genocide, they explain now emotions but in a um, big and difficult way because it did not happen the moment they explain them in the right moment. So the culture, we do explain but we don't what you call, occasion, the moment.

But the main problem is uh, is trauma. And the the trauma which is characterized by different emotions and um, some. Mainly in the period of mourning, April of every year, here in Rwanda, we meet many many many many problems of emotional problems. So, in that period, counsellors have very very hard work.

Male Suppression

No, no. Among women, it's more tolerable (to cry in public). *Men have to be strong, like a real man.* (Interviewer: laughs)

Uh, it's normal to see women crying in Rwanda but it is not normal to see men crying, in front of women. For example, if I receive in my office a man, I think he will be able to cry in front of me as women. Because, you know, I don't know how I can express that uh, in English but there, there is a ways to say in Rwanda, men cry and when they cry it going inside. I don't know if you understand They, when they cry but the l'arme, what is it in English, the l'arme, (Interviewer: The tear?) *The tear go inside it's a ways to say in Rwanda, he will cry but it don't show because they think they are power.*

Um, normally in Rwandese culture, men and women don't express their emotions on the same ways. I don't know, it's because of culture and it's because of how they have been educated. Uh, it's normal to see women crying in Rwanda but it is not normal to see men crying, in front of women. For example, if I receive in my office a man, I think he will be able to cry in front of me as women.

Men are, many are suffer but they hide themselves, they hide their suffering.

This question is interesting. It depends on the, on the gender. This one is about gender issue

Medical Connection

They don't think anything about counselling because they come to see the doctor, a physician. Nothing about counselling so they learn more about counselling when they receive counselling, okay.

Okay, now, I think psychologist and physicians are trying to break this kind of, you know traditional diagnosis or religious diagnosis by showing people that, "Hey, mental illness is a health problem, like having a broken leg or uh, a stomach problem that needs to be taken care of by medical professionals including psychiatrists and, and psychologists.

The doctor sent me for you

They have somatic problems but psychological problems they go for seeing doctor, the physican not in psychological field in the first time.

First when a Rwandan here, the first person he, he want to go see is uh the doctor, is the physical clinics and uh, traditional practicers, practice, but it is mainly the the doctors who transfer someone to counsel, to to to counsellors.

But before, when they have problem, mental problem, psychological problem, later they go to see a doctor,

They said they would take me but they want someone who did nursing as well.

Mind-body Connection

Or religious diagnosis by showing people that, "Hey, mental illness is a health problem, like having a broken leg or uh, a stomach problem that needs to be taken care of by medical professionals including psychiatrists and, and psychologists."

But when he go to a counsellor and the counsellor explain the link, yeah. The person suffering will say "Ah, that is why." But sometime, he can't know having headache, stomachache, it is due to relational things.

Multicultural Learning

Uh, as I was telling you, Rwandan are very different from West, Western people, Canada people, American people, European people. If you have to work with them, you have to know firstly, firstly, what is, what is his culture. What is, what is the the permission to do, what is not permitted to do in their culture. I think uh, in the West, in the West countries, in Canada or in the, in the America, they meet many many many people, I think so. Because they are many many movement from Africa, from Asia, from from to to these countries.

Because, for example, I I told you about the the the uh the organization from Montreal who work? They told me that they have uh therapeutic groups as they have here in Rwanda. They have therapeutic groups of different people from many countries. Because they they deal with victim of violence but mainly these victim of violence, are uh, are uh in in in exile.

I think for example, they are experience from several cultures about trauma. Mmm. So not just the West, but all over the world.

Multidisciplinary Collaboration

But now you have uh, what you call uh, it's a team it's not a psychological or counsellor here

I can have trauma I can have depression but I can have malaria, mmm, I can have uh a combination of problems I can have problem of, uh of mental problem but combinate with uh, psychal problem

Where it will be exchange, yes, to meet, to exchange, experience, to ask question, to ask information, mmm. I think it is like a network, Western, and North and South. Because we have a lot of things to learn about them and they have a lot of things to learn about, to learn about, about African people.

And anything we learn about of those people, the management of psychosocial program because we receive, like World Vision, like MSF, like how they manage the psychosocial program. Because when you manage psychosocial programs you, like in other programs, very special.

If you don't resolve the problem of justice, if I'm in injustice, it will be difficult for you to help me as a counsellor.

Ah, I'm working with um, one physician and one psychologist. I am really learn a lot from them, 'cause of such multidisciplinarity,

Yeah, for example in Rwanda, the system of social worker, it is not developed. And then they go to a counsellor sometime they they go economical issues, the go social issues, not only for counselling, yeah.

New Rapport

They think that you will give advice, like guideline. If they have problem of getting sleep, they think that you will tell them, "Do this, this and this and this." Mmm. They don't understand very well this concept, mmm. They think that you give, to give guideline, advice.

Yeah, it's a value. Because even ourselves, as as uh professions intervening in mental health, we have a kind of uh, a kind of uh mechanism. Or a kind of support for uh expressing ourself, evacuating our difficulties, our our bad feelings, etcetera.

Our trust, to be to get trust from our patient, how how to how can be our our attitude for for getting trust by our patients. Uh, our speech, what kind of speech to use for meeting, to meet uh on the level of our mind, my mind of my patient about how to to care my my speech, what, what to use? What what to to to avoid, you see

NGO/Governmental

Uh, also at national level, even if psychologists, there are some psychologists, who are in uh, in civil society, who, who can go in a, in a population in a lower level. And after psychologists, clinical psychologists, they have counsellors and after counsellors.

Who, there are many, many international organization, who have have a have mental health programs here in Rwanda. And if they they locate some, some counsellors, some psychologists, they have to deal directly with the community. They have the program, the community. They have service in their office where they see people for counselling, for therapeutic programs, psychotherapeutic programs.

A government institution, you have to pay or you use, you use the medical insurance, what you call Metuelle de Sante here in Rwanda.

But um because of actual, they pay when they are going uh public clinic, for example, neurological hospital, SCPS. And for instance for here, it's free. Mmm, for NGO it's for free, for Avega, it's for free, for other institutions, it's for free.

Pluralism

Rwanda nowadays is a mixture of Rwandan culture and many other cultures because of where people lived during their lives when they were refugees.

Rural Isolation

Because they need practice it it it I think, but they need theories. They have to need to do to to do two things between our situation. So we need training, part-time training, but we need also full training than, like high school of counsellors. And you have now a school of uh mental health in Kigali but you to be a big one to be in other areas in the country

To avoid. That's another element is uh counsellors are not in each area

Like where I used to be in Nairobi, neighbours would come to you, tell you their problems, if you can solve them, you solve them. There are so many bureaus, uh offices of counsellors. People go to them, they get helped. But here, I thought straight away I would get a job of counselling. Did I? I tried and I couldn't.

This means that there are several people who miss their appointment because of bus fare, It's too far.

I don't know if they have any chance to go in the rural area. People are not, since they are running, they become, how do you call it, mad.

Sensitization

We try to use our own ways to help them to came, because we know they need.

And then it's not interesting to for for people to, to to to to approach counsellors.

Yeah. And when someone gets mental distress, he approaches one of them

Yes, now after the genocide, with sensitization people are encouraged to go to see the counsellor. Yeah, they are encouraged but it is not in our culture.

Social Isolation

If she is there without his husband, it is a big problem for her. Because to be uh, what you call in psychology like a complex,

Uh, people think that when you are in psychological suffering, when you have something uh, going bad in your mind, you are a foolish man.

A woman who has lost her handle on her children's upbringing, a woman who misbehaves, a woman who gives a poor image of her children, people can say she is ill, take her to Ndera. So, whereas a woman who takes care of her home, the Rwandan culture welcomes her, regardless of what she does with her children. If someone says something about her behaviour, people will quickly come to her defense, say, Well, look at her children, they're well behaved, they're well brought up, she's fine. (Participant 2)

He is expected to go out there. And you know, bring in bread for the family. He's expected to um, look out after the family. Um, he's expected to, um, to be the entrepreneur, so to use the term for the family and the society. Now, failure to do that you become a weakling. You become um unresourceful. You become um useless so to speak. And certainly I believe, it will have uh, either a direct or indirect impact on your emotionality.

You stray out of what people make you to be you'll become mentally ill, you know. You, you, because you get confused, you know. Rwanda also had those roles and rules.

They even had a way of cursing you. They curse you and you become something, um, unsuccessful in your life.

Somatization

Yeah, because in your culture, in Canada, even man cries,here they can't. Some of them having headache, somatic disease.

Spirituality Impact

I remember, when I was working in neuropsychiatric hospital, I receive in my office uh one young boy. He was a solider and all member of family was died and he was with, he, he survive with two uh, member of family? No, uh one uh brother and one sister. And before Dad died, before Dad, the member of family died, they gave the whole responsibility. You are the head of the family. And during genocide he, after genocide he is going in army and he feel sad because he don't know what happen to sister and to uh brother. When he told me he say, when I find an opportunity to see my sister and my brother and to respond to they, their wish, I will never have mental problems. And we

work together as a team, we give her a weekend to stay in the family and he feel better. Because you see, 'cause it's related to how he think how he belief, you see? And those who believe to god, they think mental trouble is uh bad spirit and they call that demon, I don't know how to call?

I see that people have actually been healed, and which means I can trust that the traditional healer can help patients by using his (or her) *traditional tools.*

Therapeutic Barriers

You see for example someone lose a member of family, ask how are you, saying it's okay. He may say it's okay, but you see the face, black,

So in Rwanda I found that people in Rwanda are not uh, straightforward because I told you earlier in our discussion that they tend to keep, to be secretive.

They swallow them and show that there is nothing. God has taken his saviour, he he he's, he has taken the soul and things like that and instead of weeping, crying, the person who is dead, they will shout praise the lord. That is completely upside down. Instead of crying for what is sad, they will shout of "Praise the Lord"

Oh, I get your question well. The barrier is mainly the, the tradition of Rwandan, of holding themselves, their affairs to themselves, hmm? They, they they, they the truth, can I call it secretive?

But, several sessions, she started to cry and she told me that um, until recently you give your time to listen to me. So you see it depend on her relationship and alliance is constructed between the therapist and the client.

But psychological issue I have to explain my emotions and if I explain my emotions I explain that I need help.

Yeah. Uh, I think the counsellor or psychologist have to be careful have to, to, to, to to help but uh first uh time you have to be careful to understand to hi- to with empathy to to help with because you have to know exactly what happen because sometimes the problem is not clear

Well, it is, it is encouraged but not easy to know because people pretend to be having no problems. They can, they cover up the problems, so it is not easy to know. It is not easy to know. Unless, when you are observant and you learn how to get the non-verbals, you will know there is a problem.

Theoretical Adaptations

Rwandan culture traits have a significant role. We need to be able to understand our culture so that we can defend it and put it in a context that works with our patients beliefs.

in mental health. Um, I want them to uh, to bring um to do more research in mental health, within the Rwandan context, the African context.

We have to adapt. We have to adapt our counselling, we have to adapt our, our our approaches we studied in counselling because many approaches, approaches we we are using are from the West or these countries, where they have, they've been adapted with the people of Western countries or or people of their countries. The people who are very different from our, from our people.

We're now adapting the skills that she brought for the patients in the context of the Rwandans.

It's mental health, is related to belief. And people give concept, conceptualization of mental trouble according to their belief, according to the culture.

Western Critique

And what they bring, those people, what I had forget, in Rwanda we are still in this kind of conflict, Hutu and Tutsi. And for me, I like with, to act with people of outside, because they have distance. They have no judgment. Sometime when they have, people have to think, when you have problem you have to ask sometime. When it is Rwandese, those conflict, conflict, it can influence the relation and how to see a problem. But when these somebody of outside, he, he, he is not too much influenced by what has happened here.

To me, they are a bit more open, straight forward and uh, quick in action.

Yeah, to move to move to move people. We provide we need experience in mobilization, in to move. If I have to make people together. (Interviewer: You mean, to motivate?) *Yeah, yeah, yeah.*

They have no judgment. Sometime when they have, people have to think, when you have problem you have to ask sometime. When it is Rwandese, those conflict, conflict, it can influence the relation and how to see a problem. But when these somebody of outside, he, he is not too much influenced by what has happened here.

Such a people are not okay. So, these are the ones who we want to make understand that they are sick, they need counselling.

Western Role

Because it's it's it's very difficult to, for people to, to people from West countries to deal directly with the patients because of language, because of culture they don't know.

They bring textbooks. Go to the library here. Look at the section for Mental Health. You'll see a lot of textbooks. You can buy Canadian authors, American authors, and you know, other nationalities, you know. They bring books, they bring um, all our educational resources.

Appendix E: Themes by Code

Theme 1: Transitional Stage

Expression Beginning, Charity Ineffective, Foreign Investment, Changing Dynamics

Theme 2: Infrastructure Development

Facilities Hidden, Rural Isolation, Career Development, NGO/Governmental, Cost Accessibility,

Theme 3: Emotional Secrecy

Males Suppression, Therapeutic Barriers, Somatisation, Genocidal Trauma

Theme 4: Multidisciplinary Work

Medical Connections, Spiritual Involvement, Church Involvement, Western Role, Basic Resources, Multidisciplinary Collaboration

Theme 5: Community Integration

Genocidal Breakdown, Social Isolation, Church Support, Community Therapists

Theme 6: Speaking Outside of Society

Sensitization, Expression Change, Facing Emotions, Mind-body Awareness, New Rapport, Western Critique

Theme 7: Cultural Awareness

Theoretical Adaptations, Pluralism, Multicultural Learning