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HEALING, RECONCILIATION, FORGIVING AND THE PREVENTION OF VIOLENCE AFTER GENOCIDE OR MASS KILLING: AN INTERVENTION AND ITS EXPERIMENTAL EVALUATION IN RWANDA

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This article describes a theory–based intervention in Rwanda to promote healing and reconciliation, and an experimental evaluation of its effects. The concept of reconciliation and conditions required for reconciliation after genocide or other intense intergroup violence are discussed, with a focus on healing. A training of facilitators who worked for local organizations that worked with groups of people in the community is described. The training consisted of psycho–educational lectures with extensive large group and small group discussion, as well as engagement by participants with their painful experiences during the genocide, with empathic support. The effects of the training were evaluated not on the participants, but on members of newly set up community groups they subsequently worked with. Two types of control groups were created: treatment controls, groups led by facilitators we did not

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train, using their traditional procedures, and a no treatment control group. We controlled for other variations in the type of groups the facilitators worked with (e.g. community building versus healing) by including them in all treatment conditions. Traumatic experiences, trauma symptoms, and orientation by participants to members of the other group were evaluated. The intervention was associated with reduced trauma symptoms and a more positive orientation toward members of the other group, both over time (from before the treatment to two months afterwards) and in comparison to control groups. Our observations suggest the importance and special meaning for people of understanding the origins of violence.

During the second half of the 20th century, despite the hope after the Holocaust that such horrors would not be repeated, there has been a great deal of violence within states between groups differing in ethnicity, religion, political ideology and agenda, power and privilege (Chirot & Seligman, 2001; Gurr, 2001; Leatherman, DeMars, Gaffney, & Vayrynen, 1999; Staub, 1989). The level of violence in many of these cases was intense—in the former Yugoslavia, Sri Lanka, Rwanda and other countries in Africa, the Middle East, and elsewhere. The new century has already been preoccupied with terrorism and violent responses to it. With continuous changes in technology, values, and political systems; increased differences between rich and poor; globalization; overpopulation; aspirations by groups for self–determination; and an increase in fundamentalism; conflicts and violence between groups are likely to be a significant problem in the new century.

Preventing such violence is essential. There is likely to be a set of universal principles of prevention (Staub, 1999; 2003; Staub & Bar–Tal, 2003). However, they have to be applied and adapted to particular circumstances, so that practices will vary depending on the specifics of culture, current social conditions, and the history of group relations. Preventing conflict between groups from becoming intractable, halting the evolution of intense violence, dealing with the aftermath of great violence between groups, and preventing new violence have both overlapping and differing requirements.

In this article, we will describe an approach designed to help with healing, reconciliation, and the prevention of new violence after one group has inflicted great violence on the other, or two groups have mutually harmed one another. After such violence, how can groups that continue to live together build a better, non–violent future? While the approach we describe here was developed for Rwanda, it is based on general principles and relevant theory, and should be adaptable to other post conflict situations.

GENOCIDE IN RWANDA

We developed the approach presented here to help prevent renewed violence in Rwanda in the aftermath of the genocide of 1994. At that time, Hutus killed about 700,000 people, mostly Tutsis, as well as about 50,000 politically moderate Hutus. In addition to the killings, rape and other forms of physical and psychological violence and torture were committed. The perpetrators in this government–organized violence included members of the military, young men organized into paramilitary groups, and ordinary people including neighbors and even family members in mixed families (des Forges, 1999; Mamdani, 2001; Prunier, 1995).

As is often the case, the genocide was the end–point of an evolution (Staub, 1989), with a past history of hostility between groups. A long history of dominance by the minority Tutsis (about 14% of the population) over the majority Hutus (about 85%) greatly intensified under the colonial rule of the Belgians, who used the Tutsis to govern the country for them. In 1959, there was a Hutu rebellion, in which about 50,000 Tutsis were killed. This was followed, after independence from Belgian rule in 1962, under Hutu rule, by Hutu violence and discrimination against Tutsis, including mass killings in the early 1960s and 1970s. In 1990, a group that called itself the Rwandese Patriotic Army (RPA) entered the country from Uganda, signaling the beginning of a civil war. This was a group composed mainly of children of Tutsi refugees from earlier violence, who came by force into Rwanda at least in part because the government had not allowed Tutsi refugees to return.

Among the Hutus, an ideology of "Hutu power" developed and was propagated by elements of the government and media, intensifying fear and devaluation of Tutsis. A "Hutu Ten Commandments" advocated action against Tutsis. The genocide was planned, prepared, and then executed. The killing of Tutsis was stopped by the RPA defeating the government army (des Forges, 1999; Prunier, 1995; Staub, 1999). Subsequently, the new Tutsi government has been promoting the idea of unity and reconciliation among Rwandese.

THE IMPACT OF INTENSE VIOLENCE

The impact of intense violence on survivors is enormous. Their basic psychological needs are profoundly frustrated—their identity, their way of understanding the world, and their spirituality disrupted. These disruptions, along with those of interpersonal relationships, and the ability to regulate internal emotional states, co–exist with and give rise to intense trauma symptoms (Allen, 2001; Herman, 1992; McCann &

Pearlman, 1990a; Pearlman & Saakvitne, 1995). People feel vulnerable, the world looks dangerous to them, and other people, especially those outside their group, seem untrustworthy (McCann & Pearlman, 1990a; Staub, 1998).

Since identity is rooted at least in part in group membership, the traumatized people in Rwanda would include not only survivors (those Tutsis who lived in Rwanda during the genocide), but also those Tutsis who returned to Rwanda to devastated families, communities, and indeed their entire group (Pearlman, 2000; Staub, 1998; Staub & Pearlman, 2001). This is especially the case since many of these Tutsi returnees were not accepted and integrated in the countries of their former refuge, which strengthened their identities as Tutsis from Rwanda.

The sense of vulnerability and the perception of the world and other people as dangerous increase the likelihood that, without corrective experiences, former victims will become perpetrators. They are likely to be especially sensitive to new threat. When conflict with another group arises, it may be more difficult for them to take the perspective of the other and consider the other's needs. In response to new threat or conflict, they may strike out, believing that they need to defend themselves, even when violent self–defense is not necessary, in the process becoming perpetrators (Staub, 1998; Staub & Pearlman, 2001). This self–protective violence seems especially likely when former victims live with and are surrounded by the group at whose hands they suffered such extreme violence and when there is not yet the sense that justice has been done.

HEALING, RECONCILIATION, AND FORGIVING

Healing from the psychological wounds created by past victimization should make it less likely that victims engage in unnecessary "defensive" violence. In addition to reducing pain and suffering, healing also makes reconciliation possible. A history of violence and conflict between groups may be stopped through a peace agreement. However, it has been increasingly recognized that the reemergence of conflict and violence remains probable after such agreements (de la Rey, 2001; Staub & Bar–Tal, 2003). The peace agreement does not by itself change feelings of enmity—fear, mistrust, and hostility–that have developed. Lasting peace requires changes in the attitudes of people in each group toward the other (as well as changes in institutions and culture). This change in attitude is even more necessary after intense violence, and when the violence was stopped not by a peace agreement but by military defeat of the perpetrators.

Definitions of Reconciliation and Forgiveness

We define reconciliation as mutual acceptance by members of formerly hostile groups of each other. Such acceptance includes positive attitudes, but also positive actions that express them, as circumstances allow and require (Staub & Pearlman, 2001). Structures and institutions that promote and serve reconciliation are important, but reconciliation must include a changed psychological orientation toward the other. If reconciliation between groups occurs following intense violence, it is likely to be gradual and progressive.

Forgiving involves letting go of anger and the desire for revenge. It can help in diminishing the pain that results from victimization and in moving away from an identity as a victim. Since the definition of forgiving usually includes the development of a more positive attitude toward the other (McCullough,Fincham,& Tsang,2003), reconciliation and forgiveness are clearly connected. Understanding how the other has become a perpetrator may facilitate acceptance, but may not by itself lead to forgiving (O'Connell & Higgins, 1994).

Forgiving is at times presented as a change in a harmed party. Reconciliation is inherently mutual, a change in both parties. However, if forgiving occurs in an optimal way, that is, in response to acknowledgment by perpetrators of what they have done and apology for their actions, which have been found to facilitate forgiving (Bies & Tripp, 1998; Worthington, in press), it is likely to facilitate reconciliation and may even be regarded as an aspect of it. Especially after a genocide or mass killing, and when former victims and perpetrators continue to live next to each other, for forgiveness to be constructive, benefiting survivors and the future relationship between groups, it must have such mutuality (Staub, in press). Under such circumstances, forgiveness without acknowledgment of responsibility and expressions of regret (something perpetrators unfortunately rarely do) can be harmful. It maintains and perhaps even enhances an imbalance in the relationship and may contribute to impunity (Staub, in press). Constructive forgiveness, in contrast, may help all parties heal—survivors, perpetrators and members of the perpetrator group who have not themselves engaged in violence.

There is also a question of whom one forgives. It seems most important for reconciliation, and most likely easier (although experience indicates still difficult), to forgive members of the perpetrator group who neither perpetrated nor planned violence. That usually includes the substantial majority of the group, who may have approved of the violence or remained passive bystanders, but have not participated. Full reconciliation probably involves some degree or form of forgiving, letting go of the past, of anger and the desire for revenge. Without that, accepting the

other and seeing the possibility of a peaceful future in which the two groups live in harmony do not seem possible.

Healing and reconciliation need to go together, especially when the groups that have engaged in violence against each other continue to live together. It has been a common belief that healing for trauma survivors requires a feeling of security (e.g., Herman, 1992; McCann & Pearlman, 1990a). Healing can begin when there is at least limited security, that is, when physical conditions are relatively safe.

In Rwanda, while far from complete, physical security seemed to exist after 1999, provided by the relatively stable conditions under the rule of the Tutsi government. There has been reasonable security for Tutsis once the attacks from the Congo into Rwanda, which continued to kill Tutsis, ended. And in an absence of revenge killings and persecution, there has been reasonable security for Hutus who were not perpetrators of the genocide. However, for healing to progress for two groups living together after a genocide, psychological security must increase. Reconciliation can provide this. The beginning of healing would enhance the possibility of reconciliation, while the beginning of reconciliation would further the possibility of healing. (In 2003 and 2004, after this study was completed, there have been events that may have reduced feelings of security. A few Tutsis have been killed, and it has been assumed that the reason for this was to eliminate them as potential witnesses in front of the *gacaca*, a people's tribunal that tries accused perpetrators of the genocide (Honeyman et.al., 2004). In addition, the government began to accuse potential opposition to itself of divisionism, and take various actions against divisionists).

For reconciliation to take place, perpetrators and members of the perpetrator group who may not have engaged in violence also need to heal. Often perpetrators have endured victimization or other traumatic experiences as part of the cycle of violence. Their unhealed wounds contribute to their actions. Sometimes past trauma has been fixed and maintained in collective memory (Bar–Tal, 2002; Staub & Bar–Tal, 2003); it has become a chosen trauma that continuously shapes group psychology and behavior (Volkan, 1997, 1998). This seems to have been the case with Hutus in Rwanda, who have referred to their experience under Tutsi rule before 1959 (even though it was ultimately under Belgian rule) as slavery.

In addition, people who engage in intense violence against others are deeply affected by their own actions. Those studying and writing about perpetrators indicate that the act of killing results in psychological and spiritual woundedness (Brende, 1983; Laufer, Brett, & Gallops, 1985; Parson, 1984; Rhodes, Allen, Nowinski, & Cillessen, 2002). In order to kill another person, one must close off some of one's humanity. Empathy

and compassion must be shut down, at least in relation to the victims, especially when a person engages in repeated acts of intense violence. But closing off empathy to some people tends to spread to closing off empathy to others as well (Staub, 1989).

Those who have engaged in extreme and premeditated violence may need to maintain psychological distance from their own behavior to avoid being overwhelmed by guilt and horror. To protect themselves from the emotional consequences of their actions, perpetrators often continue to blame victims and hold on to the ideology that in part motivated, and to them justified, their violence (Staub & Pearlman, 2001). As passive bystanders or supporters of such violent acts, other members of the perpetrator group would be similarly affected, although presumably much less intensely. Thus, for reconciliation to be possible, perpetrators and members of the perpetrator group also need to heal.

AN APPROACH TO HEALING AND RECONCILIATION

We will describe an intervention we developed to help promote healing and reconciliation, and an experimental evaluation of its effects. Our aim was to contribute to healing and reconciliation in Rwanda. Collective trauma seems logically to require healing at the community level. Since the whole society was affected by the genocide, it was essential to reach large numbers of people. Highly trained staff in Rwanda were scarce. For these reasons, we developed material that could be delivered by community workers and leaders to groups of people. Our plan was not to develop a program that would replace existing approaches to healing and reconciliation; but to offer an approach which Rwandese staff, working from various perspectives, in varied settings, could integrate into their ongoing work. Working this way seemed most respectful of the natural and locally developed approaches that were already in use.

We worked with facilitators from local organizations that worked with groups of people in the community. We provided a group of these facilitators with training in this approach. We subsequently created a controlled study to evaluate the effects of this approach on the people in community groups with whom our facilitators worked.

ELEMENTS OF TRAINING

Based on our theoretical and prior applied experience, and needs and preferences expressed by Rwandese staff with whom we consulted, we designed a 9–day training program with psychoeducational and experiential components. The first three areas described below were ad-

dressed through brief interactive lectures, large group discussion, and small group discussion of the ideas from the lecture as they applied to individuals' personal experiences during and after the genocide.

1. Understanding Genocide. People often consider genocide an incomprehensible evil. People need to understand the world and what has happened to them. When others have acted in a profoundly evil manner toward oneself and one's group, people tend to blame themselves, and self–worth is diminished (Resick & Schnicke, 1996). People also often see their own great suffering as painfully unique. Learning about similar ways that others have suffered and examining and coming to see commonalities in the roots of such violence can help people see their common humanity with others and mitigate the negative attitude toward themselves. Coming to see and understand the influences that led to the perpetrators' actions, however horrible those actions, and to the bystanders' passivity, can also lead survivors of violence to be more open to reconciliation with the perpetrator group. We hypothesized that examination of the influences that lead to genocide, based on a conception that attempts to integrate psychological and cultural influences and the role of social conditions (Staub 1989; 1996; 1999), would contribute both to healing and reconciliation.

2. Understanding the Effects of Trauma and Victimization and Paths to Healing. Understanding trauma, including the classic symptoms of posttraumatic stress disorder, traumatic grief, and the profound effects of traumatic experiences on the self, can contribute to healing (Allen, 2001; Rosenbloom & Williams, 1999; Saakvitne, Gamble, Pearlman, & Lev, 2000). Coming to see that one has changed and that these changes are a normal consequence of extraordinary, painful events can ease people's distress, and promote healing. The trauma framework we provided is constructivist self development theory (McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995; Saakvitne et al., 2000). This framework suggests that the wide range of psychological, behavioral, somatic, and spiritual responses to violence are normal consequences of victimization and presents symptoms as adaptations. Providing people with a framework for recovery offers hope, a fundamental aspect of healing. The framework we used, explicated in detail elsewhere, presents core concepts of respect, information, connection, and hope as the essential elements for healing (Saakvitne et al., 2000).

Currently there is debate between advocates of a trauma framework and of a community approach to recovery. Our view is that a trauma framework that includes, but is not primarily focused on, PTSD can be extremely useful and can be applied in a community empowerment model. In our seminar, we provided a context for people's traumatic experiences that included the difficulties they face psychologically, spiri-

tually, interpersonally, socially, and so forth. We attempted to normalize the experience of traumatic stress, to depathologize the many problems people face in recovery, and to empower survivors to become active agents in their own process.

We suggest that individuals can support each other in a neighbor–to–neighbor healing process, which must include engagement with experience in the context of interpersonal support. Such engagement has two aspects: cognitive and affective. The former includes allowing oneself to know (remember, acknowledge) the things that happened to oneself or the things one did. The latter means allowing oneself to feel the emotions associated with the terrible things that happened, including the tremendous losses that are an inevitable part of traumatic experiences. Such an approach may result in a temporary increase in trauma symptoms, but ultimately it is approaching, rather than avoiding, memories of traumatic experiences that appears to offer relief to survivors (Foa, Keane, & Friedman, 2000).

3. Understanding Basic Psychological Needs. Our perspective on basic human needs is relevant to understanding the origins of genocide, the impact of victimization on people, and healing. These needs include security, trust, esteem, positive identity, feelings of effectiveness and control, positive connections to other people, a comprehension of reality and of one's own place in the world, and transcendence (or spiritual needs) (Pearlman & Saakvitne, 1995, Rosenbloom & Williams, 1999; Saakvitne et al., 2000; Staub, 1989; 1996; 2003). The frustration of basic psychological needs by social conditions is seen as one of the sources of groups turning against other groups (Staub, 1989). These basic needs can be deeply frustrated by victimization and other traumatic experiences. An important aspect of healing is the fulfillment of basic human needs.

4. Sharing Painful Experiences in an Empathic Context. This area of the training seminar was experiential. It focused on healing through writing, drawing, or thinking about one's painful experiences during the genocide, followed by sharing these experiences in small groups, with group members responding empathically to each other's stories. This process includes elements of exposure and disclosure, which have received extensive research attention (Esterling, L'Abate, Murray, & Pennebaker, 1999). Staub and Pearlman (for example, 1996) previously developed this part of the process. The participants were also trained in empathic responding.

5. Vicarious Traumatization. In addition to the content and process areas described above, we spent one session talking with the participants about vicarious traumatization (VT). Vicarious traumatization is the negative effect on the helper that can arise from working with trauma

survivors (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996). There is a considerable research literature suggesting that trauma workers may experience negative effects, parallel to, although less intense than, those of survivors themselves (Arvay, 2001). Given that many of these individuals themselves are traumatized, issues of VT are especially salient (Cunningham, 2003; Pearlman & MacIan, 1996). The goals were to give participants a framework for understanding their own experience as helpers and to encourage mutual support and self–care.

EXPERIMENTAL EVALUATION

While there have been many interventions in situations of conflict or following violence between groups, the evaluation of the effects of these interventions is usually limited and often anecdotal (Ross & Rothman, 1999). To learn whether our intervention had beneficial effects, to determine whether its more extensive use in Rwanda and elsewhere would be of value, we conducted a controlled evaluation study. We expected that over time, as measured by a delayed post–test, exposure to our intervention would reduce trauma symptoms and contribute to both Hutus and Tutsis developing a more positive orientation to the other group. However, we also expected that immediately after the intervention experience, participants might report increased trauma symptoms as a result of engaging with painful experiences. In our study, the evaluation focused not on the people we trained, but on the responses of the participants in community groups with whom our trained facilitators worked. There were both Tutsi and Hutu participants in this study.

OVERVIEW OF THE PROJECT AND RESEARCH DESIGN

The staff of the Rwandan organizations with whom we worked regularly facilitated groups in the field. These staff attended a 9–day seminar with us, which we called the Healing through Connection and Understanding Project or HCUP. Some of these staff then facilitated groups in the community, integrating aspects of our approach into their usual approaches. Working on this integration was part of the training itself.

To evaluate the effects of the intervention, we compared the results of community group participants in three conditions. These conditions included (1) the integrated condition (the experimental group), in which facilitators who had attended our training integrated our techniques with their own and then used this approach with community groups; (2) the traditional condition (the treatment control group), in which facilitators who had not participated in our seminar—who had not received

any training from us—used their customary approach with community groups; and (3) the no–treatment control condition. Participants in all of these groups completed questionnaires at three times, just before, immediately after, and two months after the treatments, assessing trauma symptoms and orientation to people in the other group. Participants in the control conditions received no treatment, but filled out the questionnaires about the same times as people in the treatment groups.

The organizations that collaborated with us varied in the goals of their work with community groups. Some aimed to promote healing, while others focused on community building. They also varied in their focus, using either a religious or a secular approach. To control for differences among community groups that may arise from these variations, we incorporated agency goals (healing vs. community building) and focus (religious vs. secular) into our design, yielding a three (treatment type—integrated, traditional, or control), by two (focus—religious or secular) by two (goal—community–building or healing) mixed design.

METHODS

The Intervention: Training Facilitators in Healing Through Connection and Understanding

The 9–day seminar included 32 Rwandese people self–identified as Hutu, Tutsi, or Twa, who were actively working as group facilitators in the community. The lectures were given in English and translated consecutively into Kinyarwanda by professional interpreters. Extensive large group discussions followed each lecture. After the large group discussions, we invited participants to engage with their own relevant experience during and after the genocide by writing, drawing, or thinking about them and then discussing them in small groups.

Content. The content of the three substantive areas (the origins of genocide, psychological trauma and healing, and basic human needs) was based on our previous work in these areas, as cited above. We developed brief psycho–educational lectures (available on our web site, www.heal–reconcile–Rwanda.org), intended to convey our conceptions in a clear and concrete manner that would allow people to connect their emotional experience to the ideas they heard. The lectures were interactive, lasting 45 to 75 minutes, including consecutive translation time. In addition to the lectures, the large and small group discussions, and the process of reflecting upon and sharing painful experiences, we worked with participants to determine the best ways to integrate these elements into their usual or traditional method of working with groups. We invited facilitators to select those elements they thought would be most useful and compatible with their usual approach. Four of these 32 facili-

tators became the leaders of our experimental (or integrated) groups for the purposes of evaluation. We recruited them on practical bases, considering their availability, willingness, and apparent ability to participate in the research. Our Rwandese associates selected the facilitators *who did not participate in our training* to conduct the traditional groups, from organizations that did comparable work to that done by facilitators of the integrated groups whom we had trained.

Participants in the evaluation study

We evaluated the effects of our treatments not on the people who participated in our seminar, but on members of community groups. These groups were newly created for the purpose of the study, but were the kind of groups, with the kind of membership, with which our facilitators usually worked.

Our research participants were 194 rural Rwandese community members recruited by local agencies; 90% of them reported living in Rwanda at the time of the genocide. The majority (75%) was female. This gender composition could be partly the result of a disproportionate number of widows in the Tutsi population after the genocide (our primary participants). (The proportion of females in the adult population, both Hutu and Tutsi, was 55% in 1999, World Bank, 2003—no data are available on the proportion of Tutsi women relative to Tutsi men). In addition, religious and civic groups tend to draw more female than male participants in many cultures. About 61% of participants reported their ethnicity as Tutsi and about 16% as Hutu or Twa; the remaining 23% either did not provide or changed their self–identification in the course of the three administrations of the measure. The reason for the imbalance in ethnic membership, as we understand it, was that, due to Tutsis' seemingly greater need of, and interest in, healing and support, agencies such as those that participated in our study tended to be involved more with Tutsi survivors of the genocide. (See discussion of issues of self–reported ethnicity in the section on demographic questionnaire, under Measures.) Participants were paid a per diem amount (approximately $2 per day) to cover costs of transportation, lodging and food for the days of their participation in the intervention. This practice and the sum paid are customary and expected in such activities in Rwanda.

Personnel of the community–based agencies recruited participants. The criteria for inclusion included having trauma–related difficulties and expressing interest in participation. These difficulties were not assessed systematically, but rather were evaluated by the staff of the agencies we worked with through informal conversation with prospective participants. Under the field conditions of the study, random assignment to conditions was practically impossible. The groups in the study

participated in different locations, partly due to where agencies were located, partly to limit contact among facilitators who worked with integrated and traditional participants. However, measures were administered both before, immediately after and two months after treatments, so that changes from before to after could be compared across treatments, and preexisting differences among groups, if present, could be statistically controlled. In addition, in the $3 \times 2 \times 2$ design, both the experimental (integrated) and the control (traditional) treatments were replicated four times (secular versus religious, community versus healing).

METHODS OF THE STUDY

The experimental and treatment control groups met with a facilitator for about two hours per group meeting, twice a week, over three weeks. On average, the groups had 16 members. The $3 \times 2 \times 2$ design resulted in four integrated, four traditional, and four control groups. One group in each treatment condition had a healing goal and religious focus, one in each condition had a healing goal and secular focus, one in each had a community–building goal and religious focus, and one in each had a community–building goal and secular focus.

Treatment: Integrated, Traditional, or Control. Facilitators in "integrated" (or experimental) groups integrated the techniques and content of our training with their standard, pre–existing activities. Facilitators integrated these new elements and techniques according to their own preferences, so there was some variety in both the techniques they chose to use and the way in which they chose to use them. Information on basic human needs was included in all four of the integrated groups, information on the origins of genocide and on trauma and grief in three, and information on psychological healing in two. Three of the integrated groups used the sharing and empathic listening approach.

Facilitators in the "traditional" or treatment control groups led participants in the standard, pre–existing intervention of their organizations. Standard activities varied widely. They were similar to those in the integrated group, except that in the latter group, elements of the training we provided were also included. The no–treatment control groups met three times, only to complete the questionnaires; they received no treatment. Participants were assigned to the treatment and control groups by the organizations whose staff led the groups and/or administered the questionnaires.

Goal: Healing or Community–Building. Half of the groups had the goal of healing from trauma, the other half the goal of community–building. Healing groups engaged in such activities as sharing feelings and

thoughts, or learning about trauma. Community–building groups engaged in and discussed such activities as income generation, agricultural work (crop cultivation, animal husbandry), or discussed housing and economic problems.

Focus: Religious or Secular. Religious groups approached their goals from an explicitly religious, Christian perspective, integrating prayer and Bible study into activities. Secular groups did not pursue their goal with a religious focus. In a country as religious as Rwanda, however, prayer is integrated into activities much more frequently than in the United States, so that even the non–religious groups may have done some praying together. This would differ from the religious–focused groups, in which there were discussions, for example, of what the Bible says about killing, discrimination, tolerance, and so forth.

QUESTIONNAIRE ADMINISTRATION

Participants completed a series of orally administered, Likert–type questionnaires immediately before, after, and two months following the end of the intervention. They were assigned ID numbers by the group facilitator and instructed to write this number on their questionnaires at each administration.

Cultural informants have told us that in answering questions, Rwandese value inoffensiveness over honesty and would be inclined to give what they perceive to be socially desirable responses. This tendency might be even more likely to emerge when the questioner is in a position of power or high status, since Rwandese also place a high value on respect for authority. Our assessment included a number of personal, painful, and challenging questions, for example, about experiences during the genocide, or attitudes toward the other group, e.g. "I often think about revenge." Several questions challenged Rwandan custom about what may be mentioned properly in public. For example, we asked questions about sexual violence, ethnicity (see under demographics), and trauma symptoms. However, while traditionally, painful feelings were not expressed in public, our experience was different. One of our authors, a Rwandese psychiatrist (AH), found in his work that this behavior has changed since the genocide. Finally, many participants had little experience with pen and paper, and less with questionnaires.

To encourage honest responding, we repeatedly stressed the confidentiality of participants' answers and the importance of their honesty and candor. All questions included a "prefer not to answer" option which participants were urged to circle rather than answering "inaccurately" should they find a question too personal or painful to answer. To increase a sense of confidentiality, participants placed their completed

questionnaires in business–sized envelopes, which they immediately sealed. Participants were assured that only the group facilitators could match their names to their ID numbers, a system that was suggested by our original seminar participants to encourage honest responding.

As many of the participants could not read, the group leader read aloud each item in sequence in administering the questionnaires. Since even participants who could not read were generally able to read numbers, they responded by marking a number on the scale. Sometimes a friend or family member of the participant helped the participant give the responses on the scale, a method Rwandese people use to vote in elections.

Clearly, the challenges in this field research required many adjustments, and created conditions that were likely to increase noise in the data. We assumed that these effects would be random across conditions, and therefore would not bias the findings.

MEASURES

Group facilitators administered to the participants a series of questionnaires about trauma symptoms, trauma experiences, orientation to members of the other group (including readiness to forgive), and demographics. All measures were translated into Kinyarwanda and were administered in the order in which we describe them here. The most potentially disturbing questionnaires, about other orientation and ethnicity, were administered last, in case they aroused strong emotional reactions, which might color responses to our other measures.

Harvard Trauma Questionnaire (HTQ). We adapted several scales from the Bosnia–Herzegovina version of the HTQ (Harvard Program in Refugee Trauma, 1999), a questionnaire designed to assess the symptoms and experiences of survivors of war and refugee trauma. The HTQ has been successfully used in the past with Cambodian refugees, Bosnian war survivors, and trauma survivors in Africa and Latin America (Basoglu, Jaranson, Mollica, & Kastrup, 2001). One of us (AH) had previously translated the HTQ into Kinyarwanda and used it in research in Rwanda (Hagengimana, Hinton, Bird, Pollack, & Pitman, 2003).

Trauma Symptoms (TS). We assessed trauma symptoms using an adaptation of the HTQ trauma symptoms questionnaire, a checklist of symptoms commonly experienced following traumatic events. The trauma symptoms questionnaire includes two subscales. The PTSD subscale assesses symptoms associated with posttraumatic stress disorder, as defined in the DSM–III–R (American Psychiatric Association, 1994). The self–perceived functioning subscale assesses other symptoms often experienced following ethno–political violence. Sample trauma symptoms from the HTQ include: "Recurrent thoughts or memories of

the most hurtful or terrifying events," "Trouble sleeping," "Feeling guilty for having survived."

To adapt the HTQ to the needs of our sample, we shortened the questionnaire by deleting several items. We then added items assessing traumatic grief and the psychological effects of experiences particular to survivors of the Rwandan genocide. Examples of traumatic grief items include: "Intrusive thoughts about the deceased," "Yearning for the deceased," and "Loneliness as a result of death(s)." These items were drawn from an expert consensus group that developed criteria for a proposed diagnostic category of traumatic bereavement for the next version of the DSM (Jacobs, Mazure, & Prigerson, 2000). Examples of questions about symptoms specific to the Rwandan genocide include: "Always feeling ashamed about the killings that took place in Rwanda" and "Feeling constant fear of being taken to prison or killed."

In order to increase scale reliability, we used as our measure of trauma a combined score for the average of all our trauma questions, those on PTSD, self–perceived functioning, traumatic grief and Rwanda–specific trauma responses. Reliabilities were .93 at times 1 and 2 and .92 at time 3. As these symptoms often co–occur in trauma survivors, combining them in this way also makes theoretical sense. However, we also did separate analyses of the subscales, with highly similar results. Still, we will briefly note some variations in the results. Higher scores on this scale indicate more trauma symptoms.

Trauma Experiences (TE). The Trauma Experiences Subscale of the HTQ (Harvard Trauma Refugee Program, 1999) consists of a checklist of common, traumatic wartime experiences, e.g., experiencing lack of shelter, lack of food or water, or the destruction of personal property. We adapted the Bosnia–Herzegovina version of HTQ trauma experiences subscale by deleting items particular to the mass violence in Bosnia–Herzegovina and substituting items particular to the Rwandan genocide. Examples of deleted items include: "Used as a human shield," "Exposure to frequent and unrelenting sniper fire," and "Forced to sing songs you did not want to sing." Examples of items added include: "Being buried alive" and "Forced to walk a long distance." These items were developed by one of us (AH) from a previous study using this measure in Rwanda. Our version of the questionnaire had 38 items (as did the Bosnia–Herzegovina version). We modified the directions to ask "Please indicate whether you have ever in your life experienced the following [events] or not." The Cambodian version asked only about events during the four years of the Pol Pot regime. The Bosnia–Herzegovina version states, "Please indicate whether you have experienced any of the following events," instructions that more closely resemble ours.

READINESS TO RECONCILE OR ORIENTATION TO THE OTHER MEASURE

With our second measure we attempted to assess forgiveness and reconciliation. Researchers and theorists have specified a number of requirements for forgiveness. We drew on these conceptualizations, and on measures that have been used (Enright, Santos, & Al–Mabuk, 1989; Hargrave & Sells, 1997; Mauger, Freeman, McBride, Perry, Grove, & McKinney, 1992). However, this prior work has dealt with forgiveness between individuals, when the offenses were often quite minimal. The requirements for forgiveness between members of groups after intense violence or a genocide may be similar, but at the same time are likely to be more stringent, and have barely been explored as yet (see Hewstone et al., 2004; Staub, in press).

We also intended to assess what we considered the essence of psychological reconciliation, the orientation to and degree of acceptance of the other. Finally, we also included items for relevant aspects of the Rwandan context. We were especially concerned with religion, which is very important in Rwanda, wanting to assess the role in forgiveness and reconciliation of people's relationship to God. Because of the conceptual nature of this measure, it was important to assess which elements, and questions, provide a coherent measure. To get an empirically meaningful measure we performed factor analyses. Under the conditions of the study in Rwanda, it was not practicable to separately administer this measure to a large enough group of people. We developed a larger measure and the items we used to evaluate treatment effects were selected from this measure based on factor analyses of responses of the participants in the evaluation study.

We developed and administered 45 items that reflected theoretical notions of forgiveness, reconciliation, and the perception of and orientation to members of the other group. We then conducted principal components analyses, and considered both unrotated and varimax rotated factors at Times 1, 2, and 3. We decided to base our measure (select the items) on the first unrotated factor of the analysis of the responses of Tutsi participants at Time 2, which gave the best results. Twenty–four items loaded above .40 on the first factor yielded by the analysis; this factor accounted for 18% of the total variance.

There were not enough Hutus in our study to do a factor analysis on their data separately. The results of the factor analysis for the whole sample were highly similar to the results of the Tutsi–only sample, but the latter seemed, substantively, a better, clearer factor, and more items loaded above our cutoff point and in that sense it was more inclusive. All but two items loaded in the same direction in the two samples, and the

two that did not both had loadings under .15. Only one item, 46, had a loading above the cutoff point in the whole sample but not in the Tutsi subsample. The five items that loaded above the cutoff in the Tutsis subsample but not in the total sample, and were included in the analysis, all had loadings over .30 in the total sample.

We also considered the factors arising from the analysis of scores on this measure at Time 1. Factors at Time 1 and Time 2 were substantially different, with the Time 1 factor conceptually less coherent. For example, with the Tutsi–only sample, at Time 1 both items expressing forgiveness (and conditional forgiveness—see below) for the other group, and items blaming oneself and one's own group and asking for forgiveness for oneself and one's group had high loadings. It is psychologically possible that victims blame themselves, especially before their participation in the treatment, in which case the Time 1 factor might make psychological sense. We therefore did analyses like those reported below, using only the self–blaming items from the measure (Items 5, 9, 17 and 18 from Table 1). These analyses showed no significant treatment effect or treatment by time interaction.

Due to its greater conceptual clarity, we decided to choose as our measure the items loading high on the first factor arising out of Tutsi participants' responses at Time 2. The factor appeared meaningful and theoretically coherent. The items related to how respondents saw the other group and their actions during the genocide; how they saw the roots of violence (i.e., the extent to which they saw it as complex and involving both parties); "conditional forgiveness" or the willingness to forgive under certain conditions (if perpetrators acknowledge their actions and/or apologize); and turning to God for help, including help in forgiving the other group. Since the factor analysis, which assesses the interrelation among items, produced different factors at Time 1 and Time 2, it is likely that these interrelations were affected by the treatment experiences. However, the factor loadings, and the choice of items for our scale, are independent of the mean values of these items, and certainly of changes in them from Time 1 to Time 2 or 3. The changes in these mean values from Time 1 to Time 2 to Time 3 are therefore valid assessments of the changes that resulted from the treatments.

Of 24 items loading above our cutoff point, .40, three were excluded to increase reliability (items 19, 21 and 24), which left 21 items. The final scale was adequately reliable (alpha=.729 at Time 1, .881 at Time 2 and .585 at Time 3 with the three items included and .811 at Time 1, .866 at Time 2, and . 682 at Time 3 with the three items excluded. The reliabilities were similar the first two times and were .75 at Time 3 when the analysis was based on the whole group). The 21 items (see Table 1, with items included in the measure in bold) have varied content but may be seen to-

gether as assessing a *readiness to reconcile*, or as a measure of participants' *orientation to the other group.* The majority of the items express feelings, attitudes or beliefs about the other group, or the willingness to forgive under certain conditions and/or with the help of God. For the sake of simplicity and consistency, we will primarily use *other orientation* to refer to the measure (OOM).

Demographics. We asked a series of questions about participants' age, gender, ethnicity, place of residence during the genocide, and so on. One of these questions, about ethnicity, was controversial. The genocide and war in Rwanda was fundamentally about ethnicity (but see Prunier, 1995 for a deconstruction of the ethnicity question). Tutsis may still fear being designated Tutsi. Given Hutu perpetration of the genocide and Tutsi rule since then, Hutus may also fear being identified by their ethnicity. In addition, the government, in its attempt to create national unity, has created a policy of not using and strongly discouraging people from using the words Tutsi and Hutu, so that their use even in common conversation was rare at the time this study was conducted. (This situation has eased since then, but only slightly.) Ethnicity information was important, but we were concerned that participants would refuse to give this information or would not report accurately, given the cultural predilection for socially desirable reporting.

In fact, close to 23% of the participants either did not report their ethnicity at any of the three questionnaire administrations or changed their reported ethnicity over the course of the administrations. For the purposes of data analysis, all of these participants' ethnicity information was treated as missing. Participants who answered the ethnicity question at only one or two administrations were assigned the ethnicity they reported at that/those time/s. Participants did not become more forthcoming in their responses to the ethnicity question over the course of the questionnaire administrations. Around 72% reported ethnicity at Time 1, 80% at Time 2, and 65 % at Time 3 (However, they may have assumed that we would already know their ethnicity).

Finally, some 5% of the participants reported that they were of Twa ethnicity. As Twa make up only 1% of the population of Rwanda and as our Rwandese questionnaire administrators assured us that there were no Twa in any of the treatment groups, we believed that those reporting that they were Twa were in fact not Twa. As described above, both Hutus and Tutsis might have had reason to hide their identities. However, comparing the numbers of trauma incidents experienced during the genocide, the Hutu and Twa groups were essentially indistinguishable. Both were clearly distinct from the Tutsi, who reported roughly five more experiences at each administration than the other two groups. The preceding discussion suggests that some Hutus might have repre-

TABLE 1. The Items Administered to Participants, with Items Selected for the Orientation to the Other (Readiness to Reconcile) Scale and Their Factor Loadings In Bold

English Version of the Items	Factor Loading
1. I have a relationship with God.	**.46**
2. God will punish those who did terrible things to the other group.	.24
3. I try to see God in everyone.	–.27
4. Each group has harmed the other.	**.46**
5. I blame my group for what happened.	.03
6. Members of the other group are human beings, like everyone else.	**.45**
7. Not all Hutu participated in the genocide.	**.60**
8. There were complex reasons for the violence in Rwanda.	**.56**
9. I feel bad about my group's acts against the other group.	–.31
10. It is impossible to understand how a group can commit genocide.	**.46**
11. I blame the other group for what has happened.	**.48**
12. I can't accept that some people who might have helped did nothing during the genocide.	**.50**
13. I feel like a victim.	**.44**
14. I forgive bystanders who did not try to help during the genocide.	.38
15. I forgive the other group.	.32
16. I have been able to mourn family members who have died.	–.24
17. I need to be forgiven for my group's actions against the other group.	–.22
18. I need to be forgiven for my actions against the other group.	–.31
19. I often think about revenge.	.47
20. I need to be forgiven for not acting in a helpful way.	.31
21. I think each group should make amends to the other.	.46
22. I could begin to forgive members of the other group if they requested forgiveness of my group.	**.55**
23. I think my group should ask for forgiveness/make reparations to the other group.	–.34
24. I would feel no sympathy if I saw a member of the other group suffer.	.61
25. I would like my children to be friends with members of the other group.	.34
26. I would not help a member of the other group who was suffering.	.14
27. I would work with members of the other group on projects that benefit us all.	.39
28. It was too dangerous for most Hutu to help Tutsi during the genocide.	**. 47**
29. My group needs to be forgiven for its actions against the other group.	–.08
30. By working together, the two groups can help our children heal and have a better life.	.33
31. The actions of some of the people in my group damaged our whole group.	.06
32. Some Hutu endangered themselves by helping Tutsi.	**.63**
33. A person from the other group helped me during the genocide.	.13
34. The acts of perpetrators do not make all Hutu bad people.	**.67**
35. The violence has created great loss for everyone.	**.53**
36. There can be a better future with the two groups living together in harmony.	**.69**
37. I can forgive members of the other group who acknowledge the harm their group did.	**.71**

TABLE 1. continued

English Version of the Items	Factor Loading
38. I can begin to forgive those of the other group who make amends for what their group did.	**.74**
39. I feel closer to God.	**.47**
40. God would like me to forgive the other group.	**.41**
41. God has forgotten me.	–.03
42. I need God's help to forgive the other group.	**.42**
43. I can forgive members of the other group who acknowledge that their group has done bad things.	**.44**
44. I can forgive members of the other group, knowing justice will be done by God.	.23
45. To forgive the perpetrators, I need society to punish those who harmed my group.	.37

One duplicate item which had a loading of –.13, is not included.

sented themselves as Twas. On this basis, Hutus and Twas were combined into one group for purposes of analysis.

RESULTS

Descriptive Statistics: Trauma Symptoms and Trauma Experiences

The median score on the Harvard Trauma Questionnaire for the number of traumatic experiences was 20. As might be expected Tutsis reported significantly more traumatic experiences over their lifetimes (at Time 1, an average of 21) than the Hutu/Twa group (average 16) $t\,(120) = 4.852$, $p < .01$). This pattern remained the same for the other two times as well, with about the same number of experiences (+/– 2) and the same significance levels.

The median score of 20 for Rwandese participants is higher than in other samples. The median number of events retrospectively reported by Cambodian survivors of the Khmer Rouge genocide was 14. This difference in events reported may have been a function of differences in instructions (see above), not only in experience. However, the instructions in our study and in the Bosnian study were similar, and participants in this latter study reported a mean of 6.5 traumatic events, about one-third the number reported in our sample.

In contrast to trauma experiences, the Tutsi and Hutu/Twa groups reported the same level of trauma symptoms at all three times (see below). There were no significant differences between these groups at Time 1, 2, or 3.

The Effects of Treatments on Trauma and Orientation Toward the Other Group

We analyzed data from both Tutsi participants only and from the whole group. Formal analyses to evaluate treatment effects could not be performed for Hutu participants only, given the small number of respondents.

In preparing this project, we were especially concerned with trauma and other orientation among Tutsis, the targets of the genocide. However, as we have noted, members of the perpetrator group are also likely to have experienced trauma. They also need to heal if reconciliation, which is a mutual process, is to evolve. In addition, while the items about forgiving in the orientation to the other measure seem more applicable to Tutsis, given that members of a perpetrator group often feel that they have been harmed, Hutus may have felt as well that the forgiving items applied to them. In sum, healing from trauma and fostering a positive orientation to the other are important for both groups.

For each measure, we will first report the analyses of the questionnaire information from Tutsis. The findings for the whole sample were usually similar. We will report the results for the whole group when it adds to or differs from the Tutsi–only analysis.

Trauma Symptoms or Trauma Impact

We performed analyses of variance (general linear model) to examine the effects of treatments (integrated, traditional, and control), goal (community or healing), and focus (religious or secular) on the dependent measures at Times 1,2 and 3. The first analysis looked at the effects on trauma symptoms. With the Tutsi–only group, with regard to our primary interest, changes in the treatment groups over time, there were significant main effects for time ($F(2, 130) = 11.75$, $p < .01$) and treatment ($F(2, 65) = 3.987$, $p < .023$) and a significant time by treatment interaction ($F(4,130) = 8.99$, $p < .001$). Considering all groups together, trauma increased progressively from Time 1 to Time 2 to Time 3. Overall the traditional group was lower in trauma symptoms than the integrated (mean difference = .285; $p < .01$). However, the significant interaction clarifies the meaning of these results.

The integrated group reported significantly more trauma symptoms at Time 1 than each of the other two groups ($p < .001$; see Table 2 showing means and significant differences). However, the integrated group improved over time (participants' trauma symptoms diminished—the difference between Time 1 and Time 3 is marginally significant, $p = .069$). In the other two groups, there was significant deterioration (increased trauma symptoms) over time (see Table 2). At Time 3, the control group had more trauma symptoms than the other two groups, which did not

TABLE 2. Means and Standard Errors of Trauma Symptoms for each Treatment Group by Time for the *Tutsi–only* group

	Treatment Group					
	Integrated		Traditional		Control	
Time	Mean	Std. Error	Mean	Std. Error	Mean	Std. Error
1	3.032[a,d]	.095	2.479[a,e]	.100	2.549[a,e]	.103
2	2.950[a,e]	.079	2.687[b,d]	.084	2.875[b]	.086
3	2.867[a,d]	.082	2.829[b,d]	.086	3.109[c,e]	.088

Note. Means with different superscripts are significant at the .05 level. The superscripts 'a', 'b' and 'c' differentiate means within columns, while the superscripts 'd' 'e' and 'f' differentiate means within rows.

differ from each other. In comparing pairs of treatment groups, the smallest number of participants in any group was 24. Since the three treatment groups differed at Time 1, we will get a better picture of treatment effects in analyses of covariance, with the initial differences among groups controlled for statistically.

The measure of trauma symptoms had several components: posttraumatic stress disorder (PTSD), self–perceived functioning, traumatic grief, and Rwanda–specific trauma responses. The analyses reported here are based on total trauma scores. Separate analyses of the subscales showed highly similar results. The results for traumatic grief were somewhat stronger than for the whole scale. PTSD scores increased at Time 2 in the integrated group, in line with our expectation that engagement with traumatic experience might temporarily increase trauma symptoms, then diminished by Time 3.

The same analysis as above for the whole group also showed a significant time by treatment interaction ($F(4, 214) = 7.762$ $p < .001$). While in the previous analysis the decrease in trauma in the integrated group from Time 1 to Time 3 was marginally significant, with the whole group it reached significance (mean difference = .178, $p = .037$). Hutus alone in the integrated group showed the same level (marginally significant) decline in trauma from Time 1 to Time 3 as Tutsis (mean difference = .161, $p = .073$).

Focus and Goal

We included variation in focus and goal primarily for control purposes. The facilitators led traditional and integrated groups, either as community or healing groups, with either a religious or secular focus (a 2×2 de-

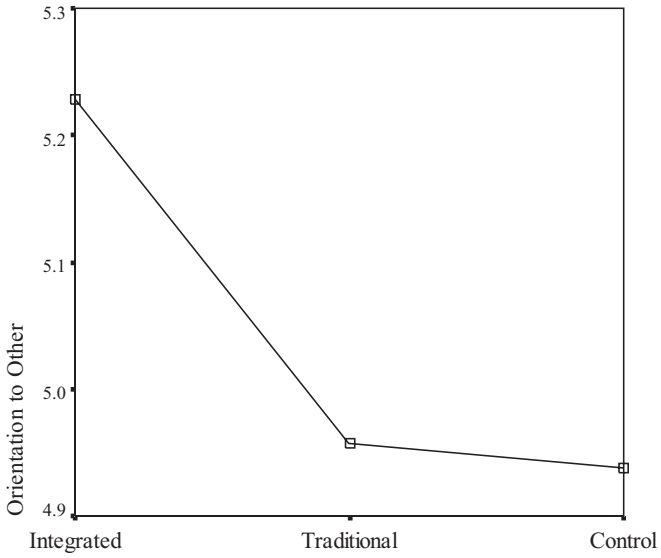

FIGURE 3. Covariance analysis of Tutsi participants' Other Orientation (or Readiness to Reconcile) Scores 2-Months Post-Intervention.
Covariates: Other Orientation Scores and Traumatic Experiences, both at Time 1

signed embedded in the treatments). Those in the integrated group combined the material they gained in our workshop with their usual approach, in a healing or community, religious or secular context. Since it is the long–term changes that are especially important, and changes at Time 2 do not predict these long–term changes, we will report the results at Time 3 involving these two variables in the covariance analyses.

Orientation to the Other

The same type of analysis of variance described above was performed with other orientation as the dependent variable (see figure 1). With the Tutsi–only group, there was a significant time by treatment interaction ($F(4, 132) = 2.637$, $p = .038$).

Here again, the integrated group had a lower other orientation score (more negative orientation) at Time 1 than the treatment and control groups, but the difference was not significant. The traditional and control groups showed no significant changes from Time 1 to Time 3. However, participants in the integrated group showed a significant increase in their positive orientation to the other group from Time 1 to Time 3 (mean difference = .417, $p < .001$). At Time 3, the integrated group had significantly more positive other orientation than the control group

(mean difference = .269, $p < .05$) and a marginally significantly more positive orientation than the traditional group (mean difference = .233, $p = .08$). To better identify the effects of the treatments, we will report a covariance analysis of treatment effects on other orientation, with the differences at Time 1 statistically controlled.

Covariance: Evaluating Treatment Effects, Focus, and Goal While Controlling for Initial Differences

Since there were differences between treatment groups at Time 1, before the treatments began—significant in trauma symptoms although not in other orientation—we performed analyses of covariance to determine the effects of treatments two months after the intervention ended, while statistically controlling for initial differences.

Trauma. We statistically controlled for differences in trauma scores at Time 1, before the intervention, as well differences in traumatic experiences that participants reported at Time 1. The analysis of covariance with trauma symptoms at Time 3 as the dependent variable showed significant differences as a function of treatment ($F(2, 64 = 9.045$, $p < .001$, focus ($F(1, 64 = 31.146$, $p < .001$), and goal ($F(1, 64) = 8.672$, $p = .005$). There were significant interactions of focus by goal ($F(1, 64) = 21.761$, $p < .001$) and focus by treatment ($F(2, 64) = 3.122$, $p = .051$).

Considering treatments, participants in the integrated group reported significantly fewer trauma symptoms at Time 3 than those in the other two groups (mean difference between integrated and traditional = .291, $p = .012$; mean difference between integrated and control = .453, $p < .001$). The other two groups did not differ from each other (see Figure 2).

Overall, at Time 3, the religious groups reported significantly fewer trauma symptoms than the secular groups (mean difference = .463, $p < .001$) and the community groups reported significantly fewer symptoms than the healing groups (mean difference = .288, $p = .005$).

Considering the interaction of treatment and focus, while overall the religious groups reported fewer symptoms than the secular groups, the integrated religious groups reported fewer symptoms than the traditional religious groups (mean difference = .517, $p = .001$) and the control religious groups (mean difference = .665, $p = .000$).[1]

Considering the interaction of focus by goal, the healing secular groups (the combination of integrated and traditional) were signifi-

1. Control groups were given values as religious/secular and healing/community because the same agencies recruited participants for both experimental and control conditions. Although control participants did not receive any intervention, we have categorized the control groups by focus and goal to control for possible recruitment biases.

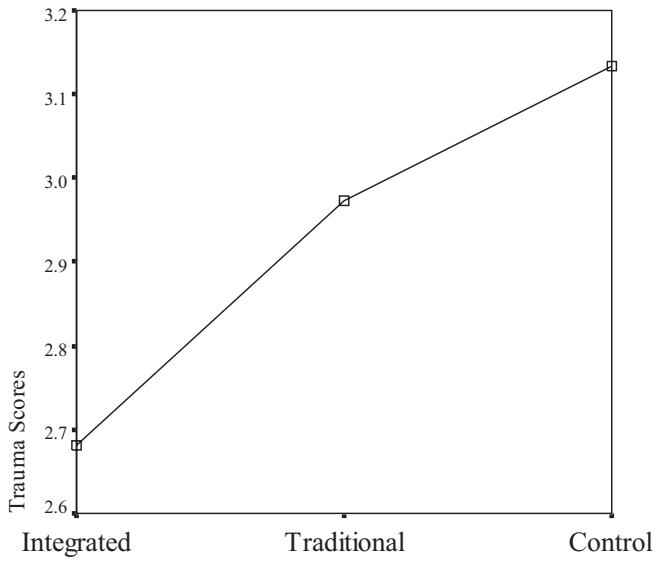

FIGURE 2. Covariance analysis of Tutsi participants' Trauma Scores 2-Months Post-Intervention.
Covariates: Trauma Scores and Traumatic Experiences, both at Time 1

cantly higher in symptoms than the other groups (on average, .755 higher, $p < .001$).

Orientation to the Other

To evaluate the effects of treatments on other orientation, we statistically controlled for differences in other orientation at Time 1, before the intervention, as well as differences in traumatic experiences reported at Time 1, in case those also moderated treatment effects. We report here analysis for Tutsis: the main findings were highly similar for the whole group.

The Global General Linear Model analysis of covariance with orientation to the other at Time 3 as the dependent variable yielded significant main effects for treatment ($F(2, 65) = 5.184$, $p = .008$) and for focus ($F(1, 65) = 15.087$, $p < .001$) (see Figure 3).

There was a significant treatment by goal interaction ($F(2, 65) = 13.055$, $p < .001$), a significant focus by goal interaction ($F(1, 65) = 8.872$, $p = .004$), and a significant treatment by focus interaction ($F(2, 65) = 3.671$, $p = .031$).

Two months after the end of the treatments, participants in the integrated condition had significantly more positive orientation to the other group than did the participants in either the traditional (mean difference

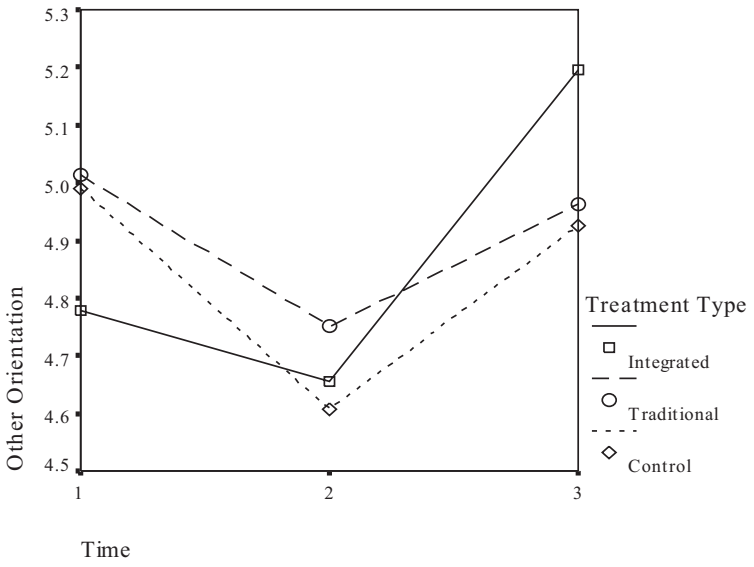

FIGURE 1. Tutsi participants' Other Orientation (Readiness to Reconcile) scores for treatment groups by time.

= .366, p = .008) or control (mean difference = .345, p = .006) conditions. High scores indicated an orientation to the other that was positive but complex. It included statements such as: feeling like a victim, blaming the other group for violence and passivity, but also recognizing that it would have been dangerous to help; that some Hutus helped in spite of the danger; that not all Hutus are bad people, and that members of the other group are human beings. The respondents saw the background to the violence as complex, with each group harming the other; saw the effects of the violence as bad for both groups; and believed that a better future is possible for the two groups living together. There was an expression of willingness to forgive under certain conditions such as the other acknowledging his/her actions and asking for forgiveness, and a request for God's help in forgiving (see Table 1).

Other analyses showed that participants in the secular conditions had significantly more positive orientation to the other group (or readiness to reconcile) than did those in the religious conditions (mean difference = .394, p = .000). Considering the interaction of treatment and goal, integrated condition participants in community groups scored higher on other orientation than did control participants (mean difference = .359, p

= .050), who in turn scored higher than traditional participants (mean difference = .581, p = .002). In the healing groups, the integrated and traditional groups had higher scores than the control group. This difference was significant for the traditional group (mean difference = .539, p = .003) but only marginally so for the integrated group (mean difference = .330, p = .057).

With regard to the interaction of treatment by focus, participants did not differ in other orientation by treatment condition in the secular groups. Among the religious groups, however, participants in the integrated conditions scored higher than those in the traditional (mean difference = .696, p = .001) or control (mean difference = .556, p = .002) conditions. (The smallest cell size in our analyses, 11, was in the traditional religious group in this analysis. Most cell sizes in evaluating interactions were in the mid–teens or higher.)

Considering the interaction of goal and focus, the community secular groups scored higher than the community religious groups (mean difference = .697, $p < .001$).

Intercorrelations Among Measures

Intercorrelations among measures at Times 1, 2 and 3 were computed, both for the whole group and because correlations at Times 2 and 3 might be affected by treatment, also separately by treatment groups. The correlation for the whole group between trauma symptoms and other orientation was negative at Time 1 (r = –.22, $p < .01$), consistent with the theoretical considerations described in the introduction. However, correlations by treatments provided a complex pattern, with sample sizes too small for meaningful interpretation.

We also computed correlations for the whole group between change scores from Time 1 to Time 3. These analyses did not yield significant results. It is possible that changes in dimensions such as healing and orientation to the other might take time to become integrated.

DISCUSSION

The results indicate that the intervention had beneficial effects both in reducing trauma symptoms and creating a more positive orientation in members of each group toward the other. Participants in the integrated group showed a decline in trauma symptoms, or trauma impact, from before the treatment to two months afterwards, while those in the other two groups reported increased trauma symptoms. Tutsi and Hutu participants in the integrated group showed a more positive orientation—or a greater readiness to reconcile, depending on how one summarizes the meaning of the measure—toward the other group two months after treat-

ments, while participants in the other two treatment groups did not change. When initial differences among groups were statistically controlled, those in the integrated group showed both significantly lower trauma symptoms and greater positive orientation to the other two months after the treatment than participants in the other two groups.

The intervention had both of the expected effects, reducing trauma symptoms and enhancing acceptance of, or a positive orientation toward, the other group. We expect the former, as an indicator of healing, to make violence by groups toward each other less likely, as well as to enable people to lead better lives. We believe that change on the second measure indicates some degree of reconciliation, or at least increased readiness to forgive (if the members of the other group acknowledge their actions and ask for forgiveness) and to reconcile. The items that indicate that forgiveness is conditional, on acknowledgement by perpetrators of their actions and on apology or regret by them, suggest that for participants forgiveness after the genocide requires mutuality. In other words, their inclination is toward a constructive form of forgiveness, or toward reconciliation.

We do not have clear answers to two important questions. First, why were there differences among groups in trauma and other orientation before the treatments? Because of the field conditions of the study, random assignment was not possible (see methods). It could be that the organizations involved assigned more deeply impaired individuals to the integrated condition. However, we do not have reason to believe that the people who constituted these groups were already well known to the participating organizations. The differences between groups could have been random. Since the two dependent variables, trauma symptoms and other orientation, were correlated at Time 1, it makes sense that given an initial difference among the groups in one of these variables, there would also have been a difference in the other. In the absence of random assignment, the study was designed so that we would be able to address initial group differences (through a combination of control groups and repeated measures and covariance analyses).

The results of both the analyses of variance and covariance show that participants in the integrated treatment changed in the predicted manner. Moreover, it seems highly unlikely, given what we know about the persistence of complex trauma (Allen, 2001) and of devaluation by hostile groups of each other (Staub, 1989; Staub & Bar–Tal, 2003) that positive changes would occur spontaneously, over a relatively short time period, in people with severe trauma symptoms five years post–genocide.

While trauma symptoms have been a substantial part of our measure and therefore we are using that term throughout, we have assessed a complex of variables including symptoms as indicated by both PTSD

items and self–perceived functioning items, traumatic grief, and thoughts and feelings about the impact of events in Rwanda. Thus, the measure assessed what may be called trauma impact in the wake of the genocide.

The second question is why was there an increase in trauma symptoms in the traditional and control groups from before the intervention to two months after it. Research findings on the effects of participating in trauma research are mixed. (For a review of this literature and the results of an empirical study, see Griffin, Resick, Waldrop, & Mechanic, 2003.) Lacking experiences adequate to address the feelings raised by the content of the questionnaires, the genocide–affected sample in our study may have experienced the reawakening of trauma–related thoughts and feelings. This interpretation would raise concerns about the common practice of administering questionnaires to people who have suffered from recent or past severe victimization or who are still in the midst of violence. This practice generally is intended to document the effects of violence, but often does not provide appropriate help with containment, processing, or healing after reactivating trauma.

The interpretation that participants' trauma was reactivated by the questionnaires also suggests that the traditional groups were not helpful in furthering healing, or even eliminating the retraumatizing effects of the questionnaire. However, it must be noted that the time participants spent in treatment sessions was very short—two sessions per week over the course of three weeks. The reason for this was practical: this was what we and our collaborators were able to arrange. Given this brevity, it may not be surprising that the traditional treatment had no positive effects. However, in light of this, the positive results of the integrated treatment seem highly promising.

A different or additional explanation might consider retraumatizing events that took place in society. There was no great new violence or other threatening events during the research period, as best we could determine from a review of western press reports about Rwanda. But conversation with Rwandese informants suggested that around the time of our project, trauma surfaced and grief became more apparent in the society as a whole. There may have been two reasons for the correspondence of this change with our project. First, the incursions by former perpetrators of the genocide from the Congo into Rwanda, with continued killings, were brought under control just before we began. And the National Unity and Reconciliation Commission was established, which started its activities by meeting various groups of people around the country, asking them what they needed for reconciliation. The activities of this commission were presented extensively in the media. With less immediate danger, psychological space for experiencing grief and loss may have

opened. With greater public discussion, memories may have been reactivated. These are, of course, speculative interpretations. However, this reasoning about the increase in trauma symptoms in the traditional and control groups would imply that the integrated group may have provided participants with experiences that helped them deal with this societal engagement with trauma. In a similar vein, research conducted in Israel found that an intervention was effective in counteracting the negative effects that the Intifada created in Israelis and Palestinians toward the other group (Salomon, 2003).

The seminar presented information and provided experiences that Rwandese helpers could use to augment their existing programs, rather than taking our whole, necessarily Western–based, program. Our belief was that this was the most respectful, as well as most sustainable/realistic approach (since this is what the facilitators would eventually do anyway). We also helped them integrate our approach with their customary approach. As we noted in Methods, facilitators used most elements of our approach, but with some variation among them. In the framework of this study it was not possible to establish whether any component of the approach was more important than any other. A dismantling study, which would be extremely valuable, would be required to make that assessment.

Experiential engagement, exposure, and disclosure, now have solid empirical support in the trauma literature as a useful approach (Esterling, L'Abate, Murray, & Pennebaker, 1999; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Rothbaum, Meadows, Resick & Foy, 2000). We believe that psychological education and experiential engagement with past traumatic events mutually support each other and are a powerful combination. In the course of our seminar, it seemed that the participants began to integrate their own experiences of the genocide with the information they received about the origins of genocide in general, and in specific instances at other places (Staub, 1989; 2003). This seemed to bring about an *experiential understanding* that had emotional meaning, rather than simply the acquisition of information. The process also gave participants hope, several of them expressing the belief that if one can understand how such things (genocides) happen, one can also prevent them. They said this not as an abstract belief, but specifically in relation to their situation in Rwanda.

Since there is relatively little tradition for the formal use of information about the origins of violence in helping people heal, and perhaps even less in helping people reconcile, we want to note our observations about the seeming impact of this information. In the training of facilitators, lectures on this material were followed by extensive discussion. In the course of the discussion, participants seemed greatly moved by the

realization that what happened to them was understandable, comprehensible, and even to some extent predictable (Staub, 1989; 2003). They came to see the genocide as the outcome, although a horrible one, of human processes, rather than of incomprehensible evil. The discussion suggested that this made them feel more human, that they felt rehumanized by it. The information about the influences leading perpetrators to their actions may also have opened them to reconciliation.

While not directly expressed in the group discussions, understanding these influences may also have begun to help members of the perpetrator group feel rehumanized. These people, who presumably did not commit violence, were nonetheless likely to feel shame and guilt, even if unacknowledged to themselves or others. Coming to understand the influences that shaped their group's actions may have eased the burden of these horrible actions and enabled them to feel empathy with the victims, which the other processes in the training were also likely to generate. This could open them to reconciliation.

FOCUS, GOAL, AND THEIR INTERACTIONS

In exploring the interactions between treatment and either focus or goal, we found that integrated groups did better than control groups and most of the time did better than comparable traditional groups. This is consistent with the overall positive effect of the integrated group, but shows that this effect held when the groups had different focus and goal. Thus, the integrated religious groups reported fewer trauma symptoms and more positive orientation toward the other group than traditional or control religious groups. The integrated community groups had more positive other orientation than control or traditional community groups. However, in the healing groups, both traditional and integrated groups (the latter marginally) had more positive other orientation than the control group.

The religious groups reported fewer trauma symptoms than secular groups, but participants in secular groups had a more positive orientation toward members of the other group. A focus on faith, on God and God's support and guidance, may have helped participants deal with their trauma. It may have provided meaning and a world view to deal with the horrors of the genocide.

However, the less positive orientation to the other——less readiness to reconcile, part of which is less readiness to forgive—by participants in religious relative to secular groups is surprising. The Catholic religion, which has been dominant in Rwanda since colonization, advocates forgiving (Auerbach, 2004). In the religious groups, facilitators used the Bible

to guide discussion rooted in Christianity. While religions advocate love of the other, in most religions there is an inherent differentiation between us, the adherents of the religion, and them, people outside that religious faith. Although there has been some evidence that religiousness contributes to forgiveness (Subkoviak et al., 1995), this appears less the case when forgiveness is across religious lines (Auerbach, 2004) and when conflict and harmdoing are between different religious groups, such as Catholics and Protestants in Northern Ireland (Hewstone et al., in press). A speculative interpretation may be that in spite of some relationship between religiousness and forgiveness, and even though in this case there was no religious difference, a general tendency for us–them differentiation may have been activated in the groups with a religious focus. It would be important to explore further this possibility, that when there are divisions between groups, whether ethnicity or something else, focusing on religious teachings can limit acceptance of members of the other group even if they have the same religion. Attention to bringing aspects of the groups' religions to the fore that advocate love may counteract such a tendency. We did find that the integrated intervention led to a more positive orientation to the other in groups with a religious focus.

Participation in the treatment groups seemed to affect Hutu and Tutsi participants in similar ways. We expected such similarity, given that both Hutus and Tutsis have experienced themselves as victimized by the other over time and, as we have discussed in the introduction, both groups need healing from their experiences in the course of the genocide.

LIMITATIONS AND BENEFITS

Lack of random assignment to conditions and possible variation in recruitment practices are methodological limitations of the study. We attempted to create a design that would enable us to deal with such methodological limitations, primarily by covariance analyses.

Before we first went to Rwanda, we intended to establish a free–standing project, with our own staff. Even then, the field conditions would have resulted in less control over elements of the study than in a laboratory experiment. However, within a day of our arrival we realized that in a country desperately needing help, such an approach would create a demonstration project without sustainability, without leaving any lasting benefit behind. We decided therefore to work with facilitators of local organizations who would continue to use the training we have provided in their work. We designed an evaluation study aware of the challenges created by our field setting and attempting to create as much control as possible.

While the differences in means were modest, finding significant results under complex field conditions seems especially meaningful. The usefulness of the approach we evaluated may be more generalizable to other field settings, possibly less likely with a "purer" laboratory study unaffected by the complexities of the field.

CONCLUSION

In this project, we developed and tested an approach to promoting healing and reconciliation. The positive results have encouraged us to use elements of this approach with varied groups in Rwanda, including high level national leaders and journalists (Staub, Pearlman, & Miller, 2003). We have also begun to train trainers in this approach. While we have not conducted a systematic evaluation study of these later efforts, our observations and informal evaluations suggest that the flexible use of elements of this approach have highly positive value (Staub et al., 2003). We would not have felt confident using the approach as we have done, without the study reported in this article. The findings of the study combined with our experience reported by Staub et al. (2003) suggest that this approach to healing and reconciliation may be useful in settings other than Rwanda, where people are struggling with the aftermath of intractable conflict, mass killing, or genocide.

Our experience in Rwanda and reports from other post–conflict settings (Agger, 1998; Agger & Jensen, 1996; Wessels & Montiero, 2001) indicate a great need for the kind of assistance that psychologists and other mental health professionals can provide. Due to the difficulties and challenges of careful evaluation of interventions, evaluations are usually anecdotal or satisfaction–based (Ross & Rothman, 1999). However, reliable systematic evaluation is possible and vital. We need confidence in our interventions, which evaluation can provide. We also need to convince those outside the field that our approaches have beneficial effects in the real world.

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