How is Community Therapy experienced in Northern Uganda?

Master dissertation II

Word count: 17472

Rottiers Aagje
Student number: 01401168

Supervisor: Prof. Dr. Derluyn Ilse

A dissertation submitted to Ghent University in partial fulfilment of the requirements for the degree of Master in Educational Sciences.

Academic year: 2018 – 2019

Abstract

Title: How is Community Therapy experienced in Northern Uganda?

Student: Aagje Rottiers - 01401168   **Academic Year:** 2018-2019
Education: Master in Educational Sciences   **Promotor:** Prof. Dr. Ilse Derluyn

After the Lord's Resistance Army left Uganda in 2006, a lot of psychosocial interventions were invented to improve the well-being of the war affected people; in specifically Northern Uganda, a post-conflict area, the need for these interventions is still high (Rokhideh, 2017). Psychosocial interventions should address the sustainability, be open for anyone in need and focus on trauma from the past as well as daily stressors (Kagee, 2018). Limited research has been done about Community Therapy, founded by Adalberto Barreto (2008), a new implemented kind of therapy in CCVS-Uganda, situated in Lira (North of Uganda) which tries to meet the previous requirements. This dissertation explored the experiences of people who attended the Community Therapy (CT) sessions in two communities in the district of Lira. A qualitative method was used to obtain a deeper understanding of the experiences. Ten participants of the study, consisting of clients, facilitators and therapists of two communities, were interviewed for five times over a period of five months. After the intake, three interviews were held with questions about the previous sessions and after two months, there was a follow-up interview. The data from these interviews was analysed through thematic analysis via the software of Nvivo. The results are divided in five themes (Practicalities, Support/Coping Strategies, Sharing, Consequences, & Evolution) with each several subthemes. The results suggest that there are some aspects of CT which work as coping strategies/support such as the cultural heritage, new obtained knowledge, the group and support outside. These support mechanisms appear to give members of CT an increased self-esteem, a capacity to solve problems and feelings of not being the only one. Other results show reasons why members would or would not share during a CT session. The members who did share had an urge to help other people, while the members who didn't share mostly kept quiet because of the lack of confidentiality, the rule of not giving advice or because the person concerning was also present. These findings imply to do further research on CT and to look closer at the practicalities for an improved working of CT.

Key words: Community Therapy, psychosocial support, Northern Uganda, sharing experiences

Acknowledgments

This dissertation is the result of an interesting and valuable year. For this reason I would like to thank some people who supported me and pushed me to keep working hard and strive for the best.

First of all I write this special thanks to my promotor Ilse Derluyn for her support and refining additions. Leen De Nutte has also been of a great importance to me the past year. She has been guiding me throughout the whole year and even in her most precious time, she was the one giving me useful feedback, tips and answers to my questions. Thank you!

Furthermore, I want to express my gratitude to Nancy Say Kana for the interesting training of Community Therapy for the staff, myself included. The time she took to read and give feedback to my interview questions are highly appreciated.

I would also like to give some special thanks to my closest family and friends who took the time to read and discuss my dissertation and for their support. I am grateful to the following persons for pushing me and helping me enjoy my breaks: Raoul Rottiers, Gilles Coetsier, Marthe Van Den Abbeele, Maud Van Belleghem, Fien en Lotte Rottiers. Mama and papa, your confidence in me, your support and the opportunities you gave me, are the reasons why I am where I am.

Finally my biggest appreciation goes to my people in Uganda. The team of CCVS-Uganda and mostly my two mentors of team-Ogur: Rebecca and Sheila. To my dearest friend, chauffeur and translator in service, Gaston, thank you so much for everything.

Other people I would like to thank from Lira, even Ogur in specific, are the two communities of Bedamwol and Apuri-Mon with mostly all the members who attended the sessions of Community Therapy. My deepest gratitude goes to the participants which I interviewed for several times. To all of you, thank you for guiding me, helping me and learning me about yourself and myself. It has been an unforgettable 8 months! Apwoyo Matek (thank you so much)!

August, 2019
Aagje Rottiers

Content

Introduction

"There is a metaphor that I really like, of being resilient and being strong and not giving up. A riddle of being a seed. Like if we were all seeds and you would put down there and you would give up, like now the soil is on top of me, there is no way I can survive this, but still the seed struggles so hard and the seeds find their way out and that is also a strength that Community Therapy gave us, we keep going." (Participant G, facilitator)

For eight months I found myself working in an NGO in Lira, the North of Uganda, to fulfill my internship and research for my master dissertation. Community Therapy (CT) was recently being implemented and I chose it as the subject of this study. I can now only hope this CT will be increasingly scientifically acknowledged and researched.

This dissertation explores the perspectives/experiences of therapists, clients and facilitators of Community Therapy in Lira and has the following 8 chapters:

The **first** chapter contains a literature review where broad concepts are explained and linked to narrow down to CT.
The **second** chapter is about the problem statement and corresponding research questions and aims as a base for this research.
The **third** chapter discusses the methodology of this study. The different steps which were taken are described.
The **fourth** chapter shows the results of the analysis.
The **fifth** chapter focuses on the discussion where the results are interpreted and connected to the literature. Subsequently the limitations and recommendations for scientific research, policy and practice are described in **six** and **seven**.
The **eighth** chapter contains the conclusion of this dissertation.

Literature review

In the following section the description of some key concepts will be made as a literature review. Since this dissertation is about Community Therapy (CT) in Lira, the background of Northern Uganda will show clarity in why psychosocial interventions are needed. Firstly, the attention is given to social support and two types of psychosocial interventions (i.e. support groups and therapeutic communities) before going into detail in the part which is called 'Community Therapy'.

Background Northern Uganda

Uganda is still recovering from the most recent civil war that persisted over 20 years between the Government of Uganda's National Resistance Army and the Lord's Resistance Army (LRA). This war has caused enormous psychosocial challenges to civilians (Branch, 2011). The north of Uganda, especially, suffered hard from the war, which caused moreover marginalization and exclusion from the rest of the country (Rokhideh, 2017). Civilians became the victim of enormous human rights abuses that ranged from murder, rape, mutilation, torture, forced labor and the abduction of over 25,000 children; these horrendous matters has led to insecurity, morbidity, mortality, poverty and distress (Human Rights Watch 2005; Isis-WICCE, 2006; Liebling-Kalifani, Ojiambo-Ochieng, Marshall, Were-Oguttu, Misisi & Kinyanda, 2008; Rokhideh, 2017). The civil war of Uganda can be seen as a 'low intensity conflict'. This kind of conflict has enormous consequences on victims:

> Low intensity conflict not only destroys property and societies, but also results in immense human costs. People are wounded, disabled or killed in violent conflict. Among the survivors, the psychological costs are immeasurable. The loss of loved ones, home, security and a normal context for everyday living disables individuals, inhibiting their ability to interact with others. The strategic infliction of terror upon innocents further deprives them of their humanity. Rape, torture, and particularly the targeting of children, all serve to strip individuals of their confidence and their sense of self. The impact of low intensity conflict is long term. (Boyce, Koros & Hodgson, 2002, p.4)

As stated above, the civil war in Northern Uganda caused immeasurable psychological costs. According to Amone-P'Olak and Ovuga (2017) war experiences are known risk factors for several mental health problems such as posttraumatic stress disorder (PTSD), depression, anxiety and behavioural problems.

After the Lord's Resistance Army left Uganda, a long transition process towards sustainable peace in Northern Uganda started. Rokhideh (2017) stated that the daily stressors people have to face in a post-conflict life should be taken into account in psychosocial interventions. Examples of those stressors or socio-economic struggles are unemployment, malnutrition, broken support systems and lack of opportunities to change their life circumstances. Armed conflict causes direct exposure to violence, death, loss and other atrocities, therefore life trajectories of children and their families become disrupted, basic opportunities for education or work are limited long into the post-conflict period (Betancourt, 2015; Brown, de Graaff, Annan & Betancourt, 2017; Tol, Kohrt, Jordans, Thapa, Pettigrew, Upadhaya & de Jong, 2010).

Warfare also has a disruptive consequence on the social fabric of communities: it brings a collective trauma and affects networks, communities and societies, that is why communities and societies will thus be challenged in a post-conflict situation in order to live back together (Derluyn, Vindevogel & De Haene, 2013). Lira District, the North of Uganda is now in a transition to peace process, in a post-conflict context. As stated above, psychological care is needed in this area. The importance of these psychosocial interventions is to not only focus on trauma, but also on current daily stressors, as well as the social fabric of the communities (Rokhideh, 2017).

Psychosocial interventions

Social support

Being exposed to war may lead to a reduction in quality of life, even after the actual conflict. Research has shown that war-affected populations have a high prevalence of mental disorders such as PTSD and depression (Matanov et.al., 2013). To improve the quality of life of war-affected populations, psychosocial interventions were developed. Interesting findings occurred in research about the protective role of social support in coping with war-related events, because of the buffering effect (Betancourt & Khan, 2008; De Nutte, Okello, Derluyn, 2017). Lasting changes in social conditions can occur due to armed conflicts. Those changes in social conditions can take place because of poverty, lack of employment, community violence, inadequate living circumstances and changed social networks (Matanov et.al., 2013). Social support has therefore a beneficial role for the well-being of a person (McAuley & Rose, 2010; Thompson, 2015). To show the importance of social networks, Cohen and Wills (1985) present two models on how social relationships influence health outcomes. Those two major models are the following: the main-effect model and the buffering model. According to the main-effect model; social support has a positive effect on well-being with or without the presence of stress. Besides, the buffering model postulates that social support can be of protection from potential damaging consequences of stress for people (Cohen & Syme, 1985). Because of the buffering effect of social support in situations of prolonged collective violence, research has shown the protective role of social support in coping with war-related events (Betancourt & Khan, 2008; De Nutte, Okello, Derluyn, 2017). These two models show us that there should be a focus on social support in the interventions which are developed for war-affect populations. Barrera (1986) defines social support as the "social interactions that provide individuals with actual assistance and embed them into a web of social relationships perceived to be loving, caring, and readily available in times of need" (Norris, Stevens, Pfefferbaum B., Wyche & Pfefferbaum R.L., 2008, p.138).

Social support can promote a sense of self-efficacy and self-esteem (Kawachi & Berkman, 2001). Within the field of post-conflict peacebuilding, the term 'ownership' has gained importance. In theory as in practice the term has the following definition: domestic actors who control the design and implementation of political processes. In a post-conflict context the term 'ownership' has something to do with peace processes connected with social support (Donais, 2009). Participation in the community can provide a sense of belonging and general social identity. According to sociological theorists, these concepts are relevant for the psychological well-being (Kawachi & Berkman, 2001).

Donais (2009) states to look at 'ownership' with different views. The liberal vision of ownership addresses self-determination and responsibilities. Another vision to ownership has a communitarian character, where tradition and social context are stressed. For something to be sustainable, it is important to be firmly rooted in domestic social realities. The local actors who need to own the intervention should have undergone capacity building. A connection with the wider community can be linked with the social capital (Kawachi & Berkman, 2001).

As stated above, warfare can cause scars on friendships, families, communities, even societies. According to Exline, Worthington, Hill & McCullough (2003), people who live in a community (that has suffered from warfare) have a past that differs from another. Where some will be a victim, others will be a perpetrator. In order to live back together, rehabilitation, reintegration and reconciliation processes need to be considered in psychosocial interventions where disruptive warfare took place (Derluyn, Vandenhole, Parmentier & Mels, 2015). Shnabel and Nadler and Shnabel (2008) have shown in their research that interaction through social exchange enhances the willingness to reconcile. In addition, the research of Staub (2006) raised the following findings; experiencing empathy with oneself opens empathy to other people. As a consequence, people may feel less vulnerable and more trusting. This facilitates the process of reconciliation where safety and trust are created. People who join together with the aim to rebuild a community after grave violence, can be a powerful avenue to reconciliation. This togetherness will enhance security and feelings of effectiveness, develop positive identity and connection and provide a new and more positive comprehension of reality.

We started by discussing the consequences of war on the mental well-being, specifically in Northern Uganda. Secondly, we talked about the importance of social support, especially within the context of 'broken communities'. Taking this all into account, a focus on the social part of interventions is important. This research will be about Community Therapy, a psychosocial intervention. This type of therapy is being implemented by an NGO in the North of Uganda providing mental health and psychosocial support services to war-affected communities. Psychosocial interventions such as 'support groups' and 'therapeutic communities' will be discussed before zooming in on 'Community Therapy'. As it will become clear, the two first mentioned psychosocial interventions share some aims and principles as the last-mentioned intervention, Community Therapy. Two types of psychosocial interventions will be described before we will go in depth about CT. Those psychosocial interventions are chosen since their principles are connected to those of CT. In this way the communalities and differences can be clarified. Another reason why the following two psychosocial interventions (support groups and therapeutic communities) will be discussed is because the limited scientific knowledge on CT, the subject of this study.

Support groups

According to Helgeson, Cohen, Schulz & Yasko (2000) a support group can be defined as a group of people who discuss and exchange information. A support group is led by a trained facilitator in contrary to self-help groups which do not have an expert leader (Helgeson, Cohen & Schulz, 2000). In a scientific research, conducted by Crabtree and colleagues (2010), the following findings were attained. Mental health support groups give persons, who have mental health issues, the opportunity to receive social support and partake in positive social interaction. An identification process with other group members who share mental health problems can take place. This kind of intervention, is called a support group and can reduce the impact of mental health problems on one's life.

According to Solomon (2004), a support group can be seen as peers who support each other socially and emotionally. Help is given and received in an area where there is respect, shared responsibility and mutual agreement of what is helpful. There is an ongoing process of "offering support, companionship, empathy, sharing and assistance" which can counter "feelings of loneliness, rejection, discrimination and frustration." (Stroul, 1993; p. 53). Davison, Pennebaker and Dickerson (2002) have shown through their research that the concept of self-help contains that people who are facing a similar challenge, can help each other simply by coming together. A formation of social relationships will take place, those social relationships can contribute to "positive adjustment and buffer against stressors and adversities" (Solomon, 2004, p. 394).

Therapeutic Communities

A psychosocial intervention for people with substance abuse problems is called a 'therapeutic community' (TC). To be addicted is a complex problem which causes issues in several life domains such as: relational conflicts, judicial issues, comorbidity with psychiatric problems, homelessness and unemployment (Vanderplasschen et al., 2013). TC's, are in the context of addictions: "drug-free environments in which people with addictive problems live together in an organized and structured way to promote change toward recovery and reinsertion in society" (Vanderplasschen, et al., 2013, p. 1).

De Leon (1998) found that people with substance abuse problems therefore get the chance to alter their drug habits as well as their character. The nature of a TC lies in a lifestyle of 'right living' to make transformations in people's lives. In this safe place, the community or group itself is used as a method to work on oneself. Frye (2004) has shown through research that the communal or family atmosphere enhances the 'treatment'. Information is shared via regular meetings which creates a sense of togetherness and belonging. In a TC people give sympathy, care and forgiveness and an opportunity is created to express feelings.

The cohesiveness and behavior code of the group is promoted through slogans, proverbs and folk sayings. Some key principles of a therapeutic community are egalitarianism, decision making by consensus, multiple leadership and 'painful communication'. [1]The goal is to reach self-actualization while listening to voices and taking responsibility.

This model centralizes:

> Learning as a social process, and this process results from two-way communication in a group of individuals who are motivated by some inner need or stress, and leads to overt and covert expressions of feeling involving cognitive processes and change in the individual's attitude and/or beliefs. (Frye, 2004, p. 267)

Critique

As discussed above, the need for provision of psychosocial humanitarian care to war and displacement affected communities has known an increased recognition (Brown, Graaff, Annan & Betancourt, 2017; Kagee, 2018). In this post-conflict context, such as the North of Uganda, psychosocial interventions should focus on trauma, daily stressors and the social networks while looking for sustainability. Rokhideh (2017) stated nonetheless that critics of current psychosocial interventions have pointed out some remarks about psychosocial interventions. They are short lived, they target specific groups which results in exclusion, and finally, they don't respond to the daily needs of the population who stayed consequently disconnected from the wider post conflict recovery process. As a conclusion can be drawn that psychosocial interventions should be responsive to the needs and changes that come up while the transition of war to peace is ongoing.
What follows will be some main points of critique about current psychosocial interventions (e.g. support groups, TC's, etc.) in order to put CT forward as an answer to these critiques.

A first remark prevails that long-term development assistance has its gaps, this because of the lack of long-term aid for peacebuilding and development cooperation in post-conflict area's (Derluyn, 2011). Given the fact that many issues remain unsolved and the creation of dependency due to the short-term approaches, there is a need to focus on sustainability in future psychosocial interventions. (Mels, Derluyn, Broekaert, Vlassenroot, 2012). Since recovery and restoration are long-term processes, interventions should be sustainable (Derluyn et al., 2013; Goodhand & Hulme, 1999; van Ommeren, Saxena & Saraceno, 2005).

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[1] Maxwell Jones (1982) wrote about painful communication. He states that social learning is often a painful process where people need to expose themselves to new ideas which means to review or overturn personal long held convictions (Taylor and Davison, 1994).

Narrow targeting of specific groups for psychosocial help is another remark of the implementation of psychosocial work implemented in northern Uganda. Interventions which were designed for small groups, especially made for former LRA soldiers can give the impression of only the 'most traumatized' who deserve special psychosocial support. (Branch, 2011; Dolan, 2002; Rokhideh, 2017).

To engage the wider community in recovery efforts is therefore a must for psychosocial interventions:

> This noncategorical approach does not only acknowledge that armed conflict—directly or indirectly—affects all children and adolescents living in the conflict area (Annan et al., this issue), but also tackles the risk of stigmatization when singling out particular (and often already contested) groups. (Derluyn, Vindevogel & De Haene, 2013, p.12)

According to Herman (1997), a possible consequence of violent conflict is a collective impact of warfare on communities. In order to heal from this impact, a relational understanding is needed as the connection between human beings can be destroyed by collective trauma. This connection can be seen as the core social fabric of families, kinship and communities and gives meaning to life experiences of people. Suffering from warfare and collective trauma arises within social contexts. Thereby, personal experiences are shaped by relational impacts. Those interconnections between the individual and the social should be taken into account in the support of post-conflict reconstruction (Derluyn et al., 2013).

As research of Derluyn et al. (2013) has shown, the impact of armed conflict and collective violence reaches far beyond the individual; it affects individuals, families, communities and even whole societies. This is why interventions should have a relational approach with an eye for individual experiences as well as collective experiences and the connection between them. The aim is to intervene with a holistic view on the long-term whereby sustainable peace-building is central. As guidelines to develop such interventions, Jacobs (2007) offers 7 umbrella concepts which should be taken into account for proper social support. These are that programs should: (1) do no harm; (2) be community-based; (3) be sustainable; (4) should build on the strengths of the community being served; (5) use local expertise; (6) address ordinary reactions to extraordinary events; and (7) offer every person in the area affected by political conflict psychological support.

Where multiple interventions don't abide with every principle, CT is a psychosocial intervention which respects every principle as stated above. Trauma and other consequences of war can have a serious impact on community members and agencies such as family, school, health and recreation. This is why CT can help to improve the well-being of people in a post-conflict situation; to rehabilitate their 'sense of community', belonging, coherence and continuity is thus needed (Ayalon, 1998). A psychosocial intervention which focuses on sustainability, the whole community, daily stressors and underlying trauma's, is Community Therapy, which will be the subject of this dissertation.

Community Therapy

The original developer of CT is Adalberto Barreto (2008). This psychiatrist, anthropologist and theologian from Brazil founded CT in the 1980s (Barreto, 2008). Barreto founded CT in order to give the people a recognition about their local knowledge, strengths and capabilities which are acquired through lived experience; he believed that via conversations with people in a context of community, meanings are given to shared experiences (Grandesso, 2015). He used different theoretical frameworks to create CT, such as systemic thinking, theory of communication, Paulo's Freire Pedagogy, cultural anthropology and resilience (Cézario, et al., 2016; Wagner, 2012). Barreto promotes therapeutic conversation to lighten the human suffering. According to him, CT gives participants the opportunity to strengthen their social network and stimulates experiential exchange. Other benefits of CT are the emphasis on competence, a creation of higher self-esteem and self-empowerment (Barreto, 200!; Grandesso, 2015; de Macedo, 2014). It is an approach which fosters a knowledge of empowerment, allowing a voice to people who felt under-represented or oppressed, by empowering individuals to speak for their own cultural traditions (Boyce et al., 2002; Cézario et al., 2016). The following definition illustrates this approach:

> A community approach endorses resourcefulness and encourages a sense of self-worth, creativity and management skills in local caregivers. It recognizes the family and community as the best setting for the recovery of children who have endured trauma, maintaining a dialogue, partnership and advocacy with affected community agencies (Pozzardi, 1995). (Ayalon, 1998, p.229)

In academic words, the definition of community-based sounds as: "efforts to work in collaboration or partnership with communities and/or settings to address local concerns and hopes for improvement" (Tricket, 2009, p. 257). This indicates that local influences are embedded in the intervention process, which navigates from problem definitions to subsequent planning, programming, and implementation (Israel, Schultz, Parker & Becker, 1998; Derluyn et al., 2013). Community support has a great importance. It activates and strengthens social networks, cultivates traditional supports and creates child-friendly spaces (Wagner, 2012).

Interventions at community level enhance the promoting of individual well-being and have the possibility to prevent or provide elements for treatment of mental illnesses (Betancourt, Meyers-Ohki, Charrow & Tol, 2013). The word 'community' includes different aspects such as togetherness, unity by common history or goal, sharing and participation in activities, culture and ideology (Webster, 1996).

Lumsden (1997) and Ayalon (1998) stated that the term 'community' derives from communication. A community is organized in a loose way although it is a social system with his own rules and interactions. An important function is to contain and support individual members as well as social systems such as family. Psychological continuity and stability can be created through a community social support system, which will enhance a sense of community for each single member.

Through his research, Ayalon (1998) has shown that the shift to the empowerment of the client is made, while enhancing resilience, coping and learning how to live in a natural life space. It is a proactive intervention where participants learn to assess their own needs and find their own resources and search and find their own solutions to their problems. Rites and rituals of their own community can be useful tools to comprehend harsh things they had or have to experience. Processes of recovery and reintegration take place at the community level while using religious and cultural methods which are meaningful to the people themselves. CT can be seen as a conversational practice organized through dialogue and collaboration. The foundation of this therapy lies within constructing identities and a way of living, whereby lived experiences and the construction of possibilities have an important role, as a result, CT contains inclusiveness and brings out organic connections in a collective space (Grandesso, 2015). People who gather together and talk and listen to each other in order to obtain a better understanding of ongoing difficulties in their lives (Anderson, 2007).
Wagner (2012) found in his research about CT that people gather in a free space to talk about their distress, problems and needs as well as about their hopes, dreams and strengths. The aim is to elevate the psychosocial well-being through sharing of experiences. People become aware of their own potential by being encouraged to talk about their suffering and recognizing feelings with other people. Via sharing and supporting, the emotional bonds and values of the local culture are intensified. As a consequence, supportive links between members of the group are created and solidarity networks are constructed with the condition of participation (Cézario et al., 2016).

Key principles

A Community Therapy is usually structured by the following six stages (Wagner, 2012; Barreto & Grandesso, 2010; de Macedo, 2014).

1) Welcoming and warming up
2) Selecting a theme
3) Contextualization the theme and linking suffering
4) Problematization sharing of local knowledge
5) Closing ritual
6) Appreciation

The themes which are chosen at the second stage can vary along the needs of the group. Themes such as domestic violence, depression, abandonment, alcoholism, robbery, sexual abuse, divorce, gang disputes, substance abuse, and many others can be presented by a participant (de Macedo, 2014). At the moment that the theme is chosen, people reflect on it by sharing experiences, looking for a language which can put their suffering into words. Such a dialogue gives people new insights and strengthens their resources and competence, in this way people learn from each other (de Macedo, 2014).

Grandesso's (2005) findings about this subject show that a Community Therapy session takes place in an open group, which is held in a public space. Since there is no fixed group, people are therefore not acquired to go to the CT each time. The participants who join a session get a single therapeutic experience. In addition, when a client attends CT many times over a long time, a long-term therapeutic process can evolve. People with different contexts (e.g., social, economic and cultural) come together. This is why there are heterogeneous groups in CT (de Macedo, 2014). The group is mixed, since there is a big individual diversity in terms of age, sex, ethnicity, social class, religion, history, etc. (Wagner, 2012). Each session is therefore different, with other shared experiences, narratives, types of communication, even with different people and at other locations. Prejudices and stereotypes need to be broken in order to let the voices speak (Wagner, 2012).

As found in the research of Barreto and Grandesso (2010), Community Therapy is not about the quest for answers or consensus. It is rather stating doubts and uncertainties whereby a process of externalizing the problem takes place. Through problematizing and contextualization there lies an importance in heightening the awareness of the problem not located in the person. Generating richer descriptions of people's skills and values through personal and collective listening, creates a sense of solidarity which can lead to the heightening of emotional and psychosocial well-being. Grandesso (2015) showed that within the community context, a common language and cultural traditions are used as tools. Relationships can be strengthened by sharing experiences which can cause a transformative dialogue. It is a process which can evolve in solidarity, belongingness and social inclusiveness. When the knowledge of either the individual or either the community is recognized, a sense of empowerment can be experienced which can give a boost in resilience.

Research question

So far, a thorough understanding of CT is still lacking, since CT has not been investigated in detail. This is why the literature review started broad and narrowed it down. In the literature review, evidence has shown that psychosocial interventions are needed within a context of peacebuilding (Rokhideh, 2017). Social support can play a protective role looking at the mental well-being (Betancourt & Khan, 2008; De Nutte, Okello, Derluyn, 2017). Concepts like 'ownership', 'membership' and 'sustainability' are of importance (Donais, 2009; Kawachi & Berkman, 2001).

It is not yet concrete how CT is experienced, how social support can have an influence on the well-being of a person and which needs need to be addressed concerning CT. The perspectives or voices from the people (who join CT) themselves are not yet heard (Barreto & Grandesso, 2010). Therefore, the choice has been made to conduct a qualitative research about Community Therapy. Members, facilitators and therapists of two communities were interviewed multiple times, to include the different perspectives and see evolution over time. Because of previous elements, this central research question results: 'How is Community Therapy experienced in Northern Uganda?'. This research question can be divided in the following sub-questions:

- How do clients, facilitators and therapist describe CT?
- What do clients, facilitators and therapist experience as helpful?
- Which specific needs do clients, facilitators and therapists describe concerning CT?

This research has multiple goals. Firstly, this dissertation wants to contribute to research about Community Therapy, more specifically the experiences are described from 3 angles, namely members, facilitators and therapists. This research could additionally optimize the therapy itself and the implementation in order to join up the needs of the NGO. This study wishes furthermore, to formulate recommendations for policy, services and research concerning CT.

As stated before, since in Northern Uganda a post-conflict situation is still ongoing, the need for psychosocial intervention is high. The emphasis on the 'social' is already made, so the direction of CT is given. The goal of this research is hereby to deepen the knowledge about Community Therapy and how people experience it, specifically in the environment of Lira District, Northern Uganda. Via a process analysis, a better understanding of how Community Therapy is experienced in Uganda, will be reached.

Methodology

To find answers to the research questions, the choice was made to use a qualitative research approach. This is a proper instrument to study the perspectives of the participants in depth (Bogdan & Biklen, 1998). Besides, a qualitative research is effective to explore topics with limited scientific knowledge (Maso & Smaling, 1998; Baarda, De Goede & Teunissen, 2001). In this way the chosen methodology forms a good connection with the research questions and aims which are described in the research question(cf. page 12).

Research setting/context

This study was conducted in Lira District in September 2018 to February 2019. The North of Uganda is still in transition to peace after more than two decades of collective violence (De Nutte, Okello, Derluyn, 2017). In this dissertation there was a cooperation with Centre for Children in Vulnerable Situations (CCVS)-Uganda. CCVS-Uganda, a center in Lira, Northern Uganda, offers different kinds of interventions promoting the psychosocial well-being of children, youth and adults in and around the Lira-district. One of those interventions, Community Therapy, is recently integrated and will now be the subject of this dissertation.

Procedure

A few steps took place before the research started. In August 2018 the researcher arrived in Lira. The researcher and some staff members from CCVS-Uganda had a meeting to brainstorm about the research design. The researcher also attended some CT sessions to have a clearer view. In September 2018, the staff members of CCVS-Uganda and the researcher followed a workshop by Nancy Say Kana [2] about CT to refresh and learn more in-depth about this new implemented therapy. In mid-September 2018, the researcher asked the clients at the end of a session if there were volunteers to join a research about CT.

After criterion selection (cf. 'Participants', p. ...), the participants were contacted. At the end of September 2018 an intake took place. When the participants gave their consent to join the research, further arrangements were made for the next interviews. An informed consent [3] was signed by the participant for agreement and to explain the aim of the research, the context of the researcher, the method and the anonymous character of the research. The permission was asked to record the interview and ethical aspects were emphasized (Mortelmans, 2011). The anonymity and the right to ask questions, stop the participation and receive contact info of

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[2] Nancy Say Kana is a Congolese Phd student at Ghent University and University of Kisangani. She is also the coordinator of CCVS-DRC in Bunia. She provided capacity training to the staff of CCVS-Uganda on the issue of psychosocial support, specifically on Community Therapy.
[3] The informed consent can be found in content of appendices, A.

the researcher in function of the research were repeated in each interview. The interview was closed with the possibility to ask questions or to add other things. The practicalities for the next interview were discussed. Finally, at the end of each interview the anonymity was stressed.

The purpose of the interviews was explained to the participants at the start and a written informed consent was obtained. The interviews took place in a setting that ensured privacy and confidentiality. The researcher and translator gave careful attention to verbal and non-verbal signs of distress during and after the interview. Psychosocial support was provided by a skilled counsellor if required or observed.

All the interviews were recorded and transcribed by the main interviewer. The transcription was according to the intelligent verbatim principal (Braun & Clarke, 2006). The average time for completing an interview was 35 minutes (range: 20-60 minutes). Apart from some drinks and appetizers, there was no compensation for the participation in the study.

Participants

Two communities in the environment of Lira were followed. The new implemented Community Therapy was observed on a regular basis in two communities. This to get an insight into what 'Community Therapy' exactly means and how it is experienced in Uganda. The goal was to analyze CT in Northern Uganda from different points of view. The following distinction is made. Everyone who is present at a session is called: 'a member'. Those members are divided in three subgroups. There are therapists, clients and facilitators. The people who were interviewed will be called respondents or participants.

Therapists are counselors who work with CCVS-Uganda and go to communities around Lira. They are trained by professionals and function as facilitators and experts, they make conversation possible and mediate when needed, for example when participants have a disagreement during therapy (de Macedo, 2014). In a therapeutic context, the community therapist can be seen as an active participant who is the architect of the dialogue, (s)he is expected to demonstrate tolerance, have professional competence, generosity and respect in order to understand the ongoing problems within the community (Wagner, 2012).

Clients are people from a same community, who are free to join CT sessions. As stated before, the group itself is heterogeneous and each session there will be different clients (de Macedo, 2014). Therefore, clients don't need to attend CT weekly, they are free to choose if and when they want to attend or not.

Each community has also two or more facilitators, chosen by the community. They attend, participate, guard and watch what is happening and help when needed during the therapy. The facilitators around Lira already got a training program of workshops where the staff of CCVS has taught them about mental health and the basics of counseling. The aim is that a therapist will slowly wipe out while supervising the facilitators leading the Community Therapy in order to be sustainable in the long end.

The selection of the participants was based on criterion sampling (Patton, 2002). People who were following CT in either Apuri-Mon/Bar-Adanga or Bedamwol and didn't miss for more than 2 times since the start. A maximum variation strategy (Patton, 2002) ensured the inclusion of participants with different ages or sexes. The selection of the participants was mostly based on the fact if they would be able to come voluntarily every week to the session as well as the interview. Overall 10 people, either client, facilitator or therapist of CCVS-Uganda, were approached for in-depth interviews on a regular basis. Some didn't sometimes show up to the interview which did not interfere with the treatment the participants were receiving. In total, 45 interviews were done including 9 females and 1 male. In each community 5 people, among those five there were 3 members, 1 facilitator and 1 therapist. In table 1, the demographic data of the interviewees are collected.

participant	age	f/m	village	function
A	34	f	Apuri Mon	client
B	48	f	Bedamwol	client
C	31	f	Bedamwol	client
D	66	f	Apuri Mon	client
E	35	m	Bar-Adanga	facilitator
F	18	f	Bedamwol	client
G	27	f	Bedamwol	therapist
H	28	f	Bar-Adanga	client
I	25	f	Apuri Mon & Bar-Adanga	therapist
J	53	f	Bedamwol	facilitator

Table 1 Demographic data of the participants at the moment of the intake

Since the clients and facilitators who participated the research, live in the village 30 km further than the office of CCVS-Uganda, the interviews with the therapist took place on different dates, that is why there are two tables with data (table 2 and 3). Another remark is the fact that sometimes an interviewee could not attend a session and therefore no interview took place. In table 2 this is indicated with 'n=3' instead of 'n=4' and in table 3 it is indicated with '/'.

	Bedamwol	Apuri Mon – Bar-Adanga
Intake	25/09/2018 (n= 4)	02/10/2018 (n=4)
First interview	10/10/2018 (n=3)	16/10/2018 (n=3)
Second interview	23/10/2018 (n = 3)	30/10/2018 (n=4)
Third interview	13/11/2018 (n= 4)	20/11/2018 (n=4)
Follow-up	12/02/2019 (n=4)	22/02/2019 (n=3)

Table 2 Dates of the interviews with the clients and facilitators.

	Bedamwol (n=1)	Apuri Mon – Bar-Adanga (n=1)
Intake	26/09/2018	11/10/2018
First interview	17/10/2018	22/10/2018
Second interview	25/10/2018	15/11/2018
Third interview	15/11/2018	/
Follow-up	27/02/2019	26/02/2019

Table 3 Dates of the interviews with the therapists.

Table 4 contains a timeline which has the aim to give visually a clearer view. From the end of September until the end of November 2018, each participant was interviewed every two weeks during those months. The intake [4]asked for demographic data and general opinions about CT. The next three interviews[5] took place the day after a CT session. Each participant was asked about the session of the day before. At the end of November the therapists of CCVS- Uganda stopped supervising and there was a hand-over to the facilitators. Which means that the community was free to continue CT, but with absence of the therapist. In February 2019, a follow-up interview [6]with each participant took place, to look back to CT. The intake, the interview and the follow-up have each 2 versions of which one is for the clients and facilitators and the other one is for the therapists.
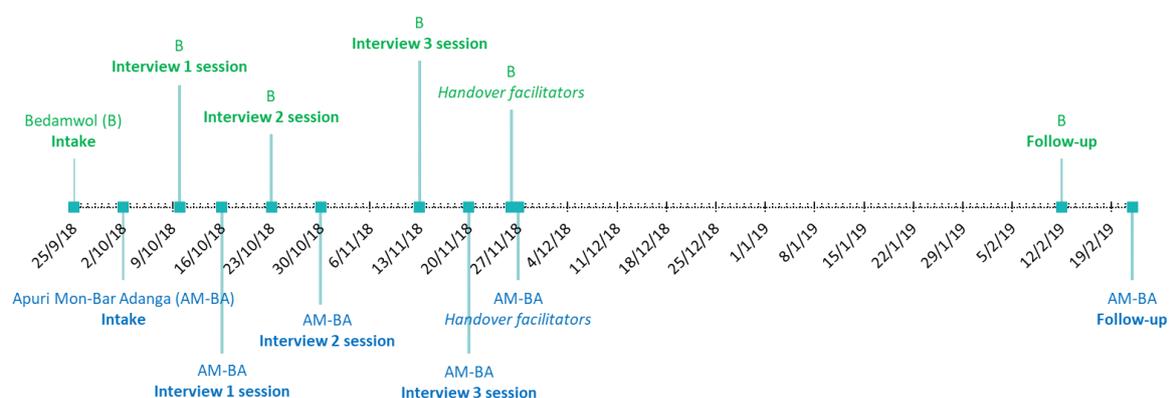
Table 4 Timeline of the interviews with all the participants.

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[4] The intake for clients and facilitators can be found in content of appendices B, for therapists in content of appendices, C.
[5] The next three interviews about the previous session of CT for clients and facilitators can be found in content of appendices, D; while for therapists in content of appendices, E.
[6] The follow-up interview for clients and facilitators can be found in content of appendices, F and for therapists in content of appendices, G.

Data collection

Qualitative research

To form a response on the research question, a qualitative research design was chosen. This research tries to discover the experiences and meaning of the participants. A qualitative approach focuses on the authenticity of experiences which creates a space for diversity of perspectives (Maso & Smaling, 2004; Mortelmans, 2011). This focus on the story of the participant creates the condition of the researcher who has to have a flexible attitude (Neale, Allen & Coombes, 2005). Because the experience of the participants is central, qualitative research seems a suitable approach and answer for the research questions (Philipsen & Vernooy-Dassen, 2004). Moreover, this type of research is indicated to research social phenomena with limited scientific knowledge (Maso & Smaling, 2004). These elements strengthen the motivation for qualitative research.

There are a lot of factors which have an influence on the execution/conduction of qualitative research: the aims of the research, the characteristics of the participants, being financially dependent or not and by who, etc. (Snape & Spencer, 2003).

The therapists and the facilitators financially depend on CCVS-Uganda. This could be an obstruction to speak freely and give their opinion, which could lead to socially desirable answers. It could also be hard for the therapist to give critique about their working or employer. The researcher tried to approach this issue and took a neutral role, guaranteed the anonymity and asked returning questions to clarify.

Instrument: semi-structured interview

In this research the participants were interviewed using a semi-structured interview. This method delivers rich data of the participants about some phenomenon (Van Hove & Claes, 2011). This instrument doesn't have the goal to make generalizing conclusions, however, the choice is made to ask in depth about a phenomenon (ibid.). A flexible, open and small structured conversation technique was applied (ibid.). In this way, the participant talks more and gets space to explore own thoughts and share the experience with the interviewer (ibid.).

After discussions with the staff of CCVS-Uganda, the promotor and Nancy Say Kana, an interview structure was made. This structure functioned as some support for the researcher and the participant (Maso & Smaling, 2004). During the interviews, the researcher created space to deepen in some subjects/topics.

The first interview took place to gather sociodemographic characteristics as well as general views on CT. Another interview which was held for the following 3 times consisted questions about the content, group interactions and personal impact of the session of the day before. The follow-up interview measured the attitude towards CT after the hand-over of the therapists.

A semi-structured interview with open-ended questions was designed to enable the participants to talk freely about their perceived experiences of the previous CT session. The questions were verified by a bicultural research team of two Ugandans, 1 Congolese and 2 Belgians. The interviews were conducted in either English or Luo (the local language) by an English-speaking researcher and a bilingual translator.

Data-analysis

In this study, a thematic analysis was conducted to generate meaningful themes out of the interviews. A thematic analysis is a qualitative method which makes it possible to identify, analyze and report data (Braun & Clarke, 2006; Van Hove & Claes, 2011). The meaning and the experience of the participant is central (Braun & Clarke, 2006).
The analysis consisted of 3 phases: transcription, coding and analyzing. Among others, Van Hove and Claes (2011) emphasize that the qualitative analysis is not a linear process, but different phases are repeated multiple times.

The first step of the analysis was transcribing the interview recordings (Maso & Smaling, 2004). Because of the literally typing of the interviews and repeated reading and going through the data, the researcher got more familiar with the data (ibid.). During this phase, the first notes were made of ideas and a possible tree structure as a guide for further analysis. In a second phase, coding, the transcribed interviews were imported in Nvivo 12. This program could give support with the analysis of qualitative data (Hoover & Koerber, 2009). Nvivo contributes to efficiency, transparency and organization of qualitative data. (ibid.). Initial codes were assigned to text fragments which seemed important to answer the research questions (Mortelmans, 2011). In this way, the researcher obtained a list with codes. Analyzing this list helped to extract bigger themes and creating a tree structure. During the selection of possible themes, it was important to be attentive if all codes could be linked to a theme. This phase was repeated and reviewed for multiple times (Braun & Clarke, 2006). Every text fragment should be representative to the code and the theme accordingly (ibid.). The themes were refined later to reach and guarantee a sufficient heterogeneity between the themes (Netwerk Kwalitatief Onderzoek, 2002; Snape & Spencer, 2003). The third phase of the analysis was defining the themes (Braun & Clarke, 2006). Starting from the research questions, the themes were organized. Eventually the researcher got a final tree structure [7] as starting point to report the results.

This method of analysis is a 'bottom up' approach to link themes strongly to the data of the research itself (Patton, 2002). A critique toward this approach, according to Braun and Clarke (2006) is the fact that this form of thematic analysis is data-driven and the results will vary along the interpretations of the researcher.

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[7] The tree structure can be found in the content of appendices, H.

Ethical considerations

Codes of ethics have been developed in the postmodern context, to give researchers an ethical framework in order to conduct and disseminate research (Marshall & Batten, 2003). According to Flick (2009) ethical considerations should be made to be more reflective as researcher. The awareness of this reflective, ethical approach toward participants should be even heightened when doing research across cultures. As noted by Marshall and Batten (2003) these ethically appropriate attitudes are the acknowledgment and integration of practices relevant to the culture and connected community of the participant.

Greatbatch, Murphy and Dingwall (2001) have, in relation with the statements above, discussed 4 subjects linked with ethical issues. These 4 subjects will be shortly explained in the following part.

The first two important ethical principles are called non-maleficence and beneficence. It means the importance of the well-being of the participant. Where the researcher should create a secure and positive environment and should avoid harming the participant (Flick, 2009; Townsend, Cox & Li, 2010). The third ethical subject which should be guarded is the autonomy or self-determination of the participant. This includes an unconditional respect towards the values, decisions and opinions of the participant during the study (Flick, 2009). The informed consent can meet this subject by stressing the voluntary principle of the study as an agreement (Hewitt, 2007). The fourth ethical principle is justice which has the aim to stress the importance of an equal treatment of every participant by giving them fair and unbiased burdens and/or benefits (Flick, 2009; Hewitt, 2007; Townsend et al., 2010). In this regards the participants of the study should have the opportunity to take the time to share and express their experiences. Each of these principles have been lived by during this study.

Marshall and Batten (2003) discussed ethical issues in cross-cultural research and state that a researcher should be aware of his/her own theoretical framework and the fact that it could differ with those of the group or culture in the research project. Those differences which could exist between researcher and participant, have to be respected and ought not to be projected as values in the research process. The researcher should recognize the probability for alterations in perceptions. While working with participants from diverse cultural background, respect has to be guarded for differing interpretations by researchers.

Quality criteria

To guarantee a qualitative research, some criteria should be taken into account. Mortelmans (2009) described that internal and external reliability as well as internal and external validity are important conditions.

Validity

Validity is about the question whether the collected data are the reflection for the existing reality (Wardekker, 2000). Maso and Smaling (2004) make a distinction between internal and external validity.

Internal validity is validity within a research project (Maso & Smaling, 2004). On the one hand does it refer to the question if the researcher measures with the instrument what he/she means to measure (ibid.). The conclusions must be valid in relation with the former collected data. On the other hand, internal validity is also determined by the quality of practice of the researcher (Wardekker, 2000).

The use of citations facilitates a good interpretation of the data and assures a better internal validity. Although there is a danger of an interference of the personal researcher's lens in the interpretations of the results. Since the researcher does not master the local language, the Community Therapies and the interviews are conducted with the help of a translator. This gives of course a difficulty in translation and interpretation of the participants input. The history and identity of the researcher will also shape the interpretation of the data. Working via Nvivo will encounter this as well as a self-critical attitude and consultation with other researchers as researcher triangulation will also strengthen the internal validity (Delodder, 2016). Guarding the internal validity will be important since there is an affiliation with CCVS. The white researcher comes from Belgium to do an internship and research in Uganda. The frame of reference will thus influence the interpretations of the researcher. A critical attitude to the researcher's personal lens is therefore acquired.

External validity refers to the ability to generalize the results to other populations in other times and places (Maso & Smaling, 2004; Mortelmans, 2011; Wardekker 2000). In practice, the ability to generalize is not always realistic (Maso & Smaling, 2004).

Generalizing qualitative research is difficult in order to reach external validity (Mortelmans, 2009). To become theoretical generalization is not the aim of the study; certainly since the research population is rather small and gives no realistic representation.

Reliability

Reliability refers to the extent if the results are independent of coincidence (Maso & Smaling, 2004). A distinction is made between internal and external reliability (ibid.).

According to Mortelmans (2009), data of the same subject should be comparable to be internally reliable. Internal reliability is reliability within the research project (Maso & Smaling, 2004; Mortelmans, 2011). It is about intersubjective approval of the different members of the research team (ibid.). Since this research is conducted by only one researcher, it is not possible to test the conclusions to the interpretation of other researchers. The internal reliability is extended because of the use of a dictaphone during the interviews and the use of computer software (i.e., Nvivo) for the analysis (Maso & Smaling, 2004). The coding program is a useful instrument to code the transcribed semi-structured interviews to same concepts.

External reliability refers to the ability to repeat the research by other independent researchers in the same situation, with the same research plan and with the same methods (Maso & Smaling, 2004; Mortelmans, 2011). Repetition of the original research is not always possible though, because the research object as well as the setting can change over time (ibid.). There is then only mentioning of virtual repetition where the research situation should be as transparent as possible (Maso & Smaling, 2004; Mortelmans, 2011). External reliability can be reached by replicating a study, but to replicate a qualitative study is not evident, although a good outlining of the process of the study will tend to a better replication (Mortelmans, 2009). In this research the external reliability is extended through detailed description of the different steps, the use of citations at the results and keeping all the audio records, the transcribed interviews and field notes (ibid.).

Results/Analysis

In this chapter, the results of the data-analysis will be presented. The following findings show how CT is experienced in Lira, North of Uganda. The following distinction is made. As stated before: everyone who is present at a session is called: 'a member'. Those members are divided in three subgroups. There are clients, facilitators and therapists. The people who were interviewed will be called respondents or participants.

In the citations, sometimes participants talked about other people. Therefore, pseudonyms were chosen to guard the anonymity of the participants and their environment in this research. At the end of each citation, there is a reference to a table of characteristics of each participant (table 1, p. 15).

The following citations used in the analysis to ground the findings, are literally spoken words of the participants. Since their mother tongue is Luo, an interpreter was there. This could cause some sentences which are not correct gramatically. The researcher chose to stay as close to the data as possible and didn't change the words of the participants.

To answer the questions how CT is experienced, a qualitative study took place. Multiple participants (n=10) were interviewed for multiple times (5#). These data were analyzed using the qualitative analysis program Nvivo and after actively looking for trends, the following results were obtained. The findings are presented around 5 major themes: rules & practicalities, sharing, coping strategies/support, consequences and evolution.

Rules and practicalities

One theme which emerged out of the interviews was 'Rules & Practicalities'. This is more about the practical side of CT, how it is implemented and what the guidelines are. In this part the following aspects are described: the constitution of the group, time management, confidentiality and the problem of advice-giving.

Constitution of the group

When asked about the constitution of the group, several participants reported that the mix of people in the CT was a good thing because in that way people learn a lot from each other and a conflict is easier to solve. A participant even said the following:

> *"The mix of people leads to development of the group. Because even the older people think about their future."* (participant A, client)

One of the therapists strived for a closed group. According to the therapist the trust would increase, the members would share more and the confidentiality would be kept.

> *"CT being an open group, I think one way it is, the new members who keep coming, at times it is hard for the grounded old members for them to learn to trust them. I recommend that with time the CT group should be like a closed group, where if these specific people, they're journeying/joining with the group sessions all have to finish that before other new members enroll in, because if they were to enroll when the other old ones were already there, the trust between them and the new comers, I think it can be hard, because a new person coming in and like getting to trust and sharing openly, it can become hard, but if they are these only people who have started from session 1 and up to, I think the trust level and the level for sharing can be much better than other people keeping quiet and sitting and going out like that, I think it is important they restrict in how many people are coming. Because it disrupts people."* (participant I, therapist)

However, there was also a wish by multiple participants (n=8) to invite more people, new people. To let the group be bigger.

> *"And also CT is open, it allows anyone at any point to join, because there are other people who join in the middle, there is no limit for anyone to join."* (participant G, therapist)

Although there was a mix of people, there were still significant more females than males attending the sessions based on field observations. In the interviews the participants stated to want more men in the group. Multiple participants wanted new people in the group, and most of them pointed out to also attract men to the sessions; the only male participant in this research explained why.

> *"Yes, there are other people that always hear that CT always helps, but if those people come to us, because most people are women, and they go back, their husbands grow annoyed: why do they have to come here? Most of those men think that their women don't have to report that because sometimes the husbands are drunk or use violence and they don't want the woman to reveal that problem. The husbands are afraid of the secrets who will be spread in the communities on drunkenness and violence. They always go in the field, men don't report, only women report. Men they don't report because they don't want their secrets to come out. Women they say because it touches them. Actually, we need more men in the group to make them go together with the women."* (participant E, facilitator)

Time management

Another important aspect was time management. Since CT is open and people can arrive at any time, people could also come late. Even if the people were late, it was still okay and they still highly valued the session. However, according to both the facilitators and the therapists, it is important to keep time. Because members who are late disturb and disorganize the session.

> *"The weakness of the CT is that other people don't follow time, I can ask/commend to them to come at 14h, but they can come at 16h."* (participant J, facilitator)

> *"Another challenge I find if I prevent myself when I go into a session, then the members come late. I find it hard and with those ones who come late and start greeting and pull attention, it is quite challenging."* (participant I, therapist)

Some members also pointed out that if they are late, they can't share anymore what they wanted to share.

"I was having pain at home, so I decided to come and share with people so that I would get better. I wanted to share but I was late. I came very late so it was not possible to mention what I was having. I never regretted, I heard what they were saying, I was just ok." (participant C, client)

Confidentiality

Most of the participants also brought up the confidentiality. Confidentiality is a rule of CT and everyone needs to respect this rule. When asked if he/she would talk about the session to someone who didn't attend the session, this is what a respondent answered:

> *"No, because we have a law in the group, if we share something in the group, you have not to hear it out anyhow. You have to keep it as a secret."* (participant H, client)

Because people who attended a session did sometimes talk about the content outside a session, they broke confidentiality. Talking about the session was either because people wanted to gossip or because they wanted to 'teach' those ones who didn't attend. Breaking confidentiality, however, could result in a breach of trust between the person and the member/group:

> *"Also, someone told my husband my experience what I was telling in the group. So, my husband was quarreling with me because some people gave me different solutions. So, there was a bad impact on my husband and also the relation with the other group members because she broke the confidentiality."* (participant C, client)

Advice giving

In both the communities, the problem of advice-giving occurred. When someone presented his/her problem, other people wanted to give advice and tell that person what he or she should do. The facilitators and the therapists pointed out that CT is not about giving advice but sharing experiences. This sometimes caused confusion or even fear to open up in the group.

> *"For me, I used not to understand about giving advice, but what they mentioned yesterday that you have to share your own experience, made me to differentiate with giving advice and sharing."* (participant H, client)

This is why there was an idea to be attentive as a group to stop the advice giving, by doing a sign which would be made if the person went afield.

> *"No one gave advice, but by the time we were sharing, other people moved astray and tried to give advice, but the therapist tried to stop them… We were showing a sign, so that you have to stop if you are giving advice."* (participant A, client)

Coping strategies/support

Analysing the interviews helped us to extract another theme which is called 'coping strategies/support'. This theme consists in the way of handling with problems, which elements of CT help to get over problems or difficulties. Four main subcategories were divided and pointed out as ways of support: the cultural heritage, new knowledge, the group and the outside.

Cultural heritage

The first one is called: 'the cultural heritage', which means mostly songs, dancing and metaphors. These elements are culturally connected. The songs, the dancing and the metaphors are locally originated and are highly valued within the communities. After singing a song or dancing, people simply feel better. Metaphors can also have important meanings.

> *"Last time there was an example about a certain tree, like a metaphor, that even if the wind is too much, it just bends and comes back, so that is how I am."* (participant J, facilitator)

> *"And also when they sing and dance, it brings back the group cohesion and it also reminds us about the culture, so much. You see how people, even weak or old people, they are so happy."* (participant G, therapist)

New knowledge

Another type of support the participants talked about, was 'new knowledge'. This is perceived as new things they got to learn from others who shared with them. CT is about sharing experiences, those experiences were mostly about several topics which were discussed in both the communities for multiple times. The several themes which had a big impact on the participants were the following: alcohol abuse, business, farming, illness, in-laws, loss, neighbors, pain, school fees and violence. About these themes people shared experiences and this helped to strengthen people with new knowledge on how to overcome their problem.

> *"I attend the group; it teaches me a lot of ideas. When you come here, you turn an old idea to a new one, this changes your life."* (participant B, client)

> *"It learned me something, because if you are having any problem, you have to know the way of overcoming it or persevering. It was only for yesterday. Because if you are having like a disease you have to know the way of controlling it or going to the doctor."* (participant J, facilitator)

This 'new knowledge' contains also the counseling part. Where people feel strengthened in their ability to help others. They gained specifically counseling knowledge. Not only the facilitators, but also the clients.

> *"I know how to counsel now. I know how to help others."* (participant B, client)

> *"I have learned the way of helping people who are having problems... Yes, other people are bringing the reports/the results of what we have shared here, it is helping them a lot. It has changed my life in the way of talking to people. I am even having knowledge of knowing how to help people, this gives me strength."* (participant E, facilitator)

Group

The third subcategory is called 'group' because it refers to the relationships between its members. The participants talked about friendship and togetherness, of the feeling of being a member, the support of others and also of helping others. The last two mentioned are the fact that they perceive support from members of the group but they also feel strengthened when they can help other members.

> *"Yes, I am now having the knowledge of sharing with someone who is hurt. Now I know more how to help other people. If someone is hurt, I can put the person down and share."* (participant A, client)

> *"Group members help me, when I have a problem, they can help me in my life."* (participant C, client)

> *"The friends we are making there, is building happiness in us. So, when we are together, we're just happy. … For me, I had the experience and it is the group that helped me, that's why I decided to help the other friend. … I learned that staying together as a group can help you if you are having anything, even if it is big like what."* (participant D, client)

> *"The group has helped me, my problems from the past are going away."* (participant F, client)

Outside

The fourth subcategory has the name 'outside'. Coping strategies can also come from outside, such as the wider environment of members or religion.

Friends, family, neighbors, people who don't attend CT, but are supportive for the person to join the session, this can be of big support.

> "*I am getting changes in me and with all of the people surrounding me. Yes, because I was getting changes that is why they are happy for me coming here. ... Yes, many people came and it has made me with confidence that all the people of the community are supportive with what I am doing.*" (participant J, facilitator)

> "*We have changed it in this way, before we had a woman who was doing it alone, but now women and man all of us are working together. Before women were not thought to work with men and now because of the CT, the man sees the wife and thinks 'oh my wife has changed, so let us work together'.*" (participant D, client)

Even though the environment can be supportive to a person, it is also possible the other way around. In this way that the closer network of a member can be a burden, not supportive at all to the member. As an example, the following quote of a participant is presented:

> "*My husband was not supportive because maybe last time I mentioned my problem, but my mother to my husband was there, so this mother went and told my husband. So that is why he was not supportive.*" (participant C, client)

Another type of support according to the participants was spiritual support. Praying alone or in a group gave the participants relief and supported them when they were feeling down or were having mental problems.

> "*Yes, what I picked from yesterday's therapy was that the way somebody says that she overcomes the problem by praying, that is what I picked.*" (participant B, client)

As a side note to this subcategory it is important to state that different participants talked about the support of CT even after the session. In this way they were talking about getting support from CT, even if the session was already terminated. According to the participants the support doesn't stop after the session. This is a kind of coping strategy, to share experiences even after the session.

> "*And also now, when I am going through something that is disorganizing me, I normally think of CT. Sometimes when we are talking and some personal stuff or work-related, sometimes we talk about it, like we are going to share our experiences and it is helping us to cope and also to find solutions by sharing. When I share with friends or colleagues, it makes me think as a CT.*" (participant G, therapist)

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Sharing

In CT you have mostly one, two or three people who present a problem, after explaining it, people can share. This theme is about the sharing during a session. Here we will have a closer look on why participants did or did not share.

Did not share

Sometimes participants didn't share. People can fear to open up to the group. This because of the fact that there is no trust and no confidentiality. Since people break confidentiality, other members of CT don't want to share their problems/thoughts. They fear that if they would share, other people would spread it.

> *"It has not created any change, because they are not keeping secrets. If you come with your problem here, they are waiting, they go back home and then they spread it anyhow. Then it will again cause you another problem. I trust the group though, because I always keep the secret. But if I hear out my problem, I stay like for 2 or 3 days and I hear again someone talking about my problem. So I used to fear bringing out the problem. I would hear out my problem if those talkative people were not there, but if they are there, no."* (participant C, client)

Since the clients who attend CT ought not to give advice, a fear engendered to talk openly. The facilitators and therapists would request every time to stop the advice giving. This is seen as counterproductive because the members would rather keep quiet then make a mistake. Since the facilitators and the therapists have been guiding the members about not giving advice, members of CT didn't dare to speak up anymore. The fear of making a mistake was sometimes too big.

> *"If you entered into giving advice, they stopped you from there. The therapist stopped us, if you start sharing and it turns into giving advice, they stop you from there. Then many people got afraid of sharing, because it got somehow hard."* (participant A, client)

Or they didn't share because of the fact that it was already said. Or the emotions were too high and the members were too caught up in the story. Or there was no respect of other members.

> *"For me, what I was supposed to say, I found already that they were mentioning it, so it was hard for me to say something. What I was supposed to say, Constantine mentioned it and even other people were mentioning it. I never regretted that I didn't say anything, because many people were saying what I was supposed to say."* (participant F, client)

> *"It triggered so many people, like so many people cried, at that moment I was helpless, I really didn't know what to bring out, it really touched the person that shared and other people who were touched by the story."* (participant G, therapist)

Another reason why participants didn't share was because of the presence of a person who was involved in their problem. The person concerning the difficulties was also there and this held back the participants to share. But on the contrary, although the person concerning was there, members still shared.

> *"The disadvantages that I got, in this group there were people who were sharing husbands, so if that person is having a problem, she cannot mention, because, even the other woman is there."* (participant B, client)

> *"Because of the fact that everyone is together, it is sometimes hard to share. So, people hide things because there are older/younger people or men/female."* (participant J, facilitator)

If people talk about a certain topic which the person didn't live through, it is harder to share. Since he/she doesn't have the experience. This is also a reason why people wouldn't share in the group.

> *"I never shared because I don't have the experiences, but I heard what they shared."* (participant B, client)

Did share
Participants did also share. All the participants talked about the fact that recognizing was a big reason why they would share. They had the same experience and had a feeling to share.

> *"I shared. I had a similar experience before, so I shared the experience with Harriet about the headache and then I told Harriet the way I overcame my headache."* (participant A, client)

A second reason why people felt they would share was because of the emotions. What the members were talking about, awakened the participants and gave them the feeling to share.

> *"The problem that Jennifer was having, touched me and made us to share to correct the problem."* (participant D, client)

Or people shared because they were feeling okay, they were in peace and wanted the other to feel good as well.

> *"What made me consider was that I came to share with people. I wanted only to share, to help people."* (participant A, client)

Consequences

Another big theme we could extract from the analysis of the interviews is 'consequences'. What kind of impact CT had on the participants.

They talked about 'forgive and forget', about positive changes in oneself. Participants talked about the fact they felt stronger, their self-esteem grew and their self-reliance increased.

> *"The benefit that I encountered is that it brought change in my life. Before, if I had something or someone told me something that made me annoyed, I couldn't easily forget, but now even if someone is telling something wrong about me, I can just stay okay. I become stronger and if something goes wrong now, I can give it a place."* (participant J, facilitator)

Attending a session of CT also helped with possible problems or to solve current problems. They felt that with the sharing of others about topics they were struggling with or thought they would struggle with later, they could solve these problems.

> *"Yesterday when I came, what I shared, it helped me. The pain in my chest got relieved, when I got home, I remembered. Sharing helps me so much."* (participant A, client)

> *"The session of yesterday helped me personally, it has built confidence in me, because I heard what they have said or the other problem that she was having. For me now, I am ready for any illness that would come on me. … It was difficult for me because I didn't have the experience. For me, I was thinking that one day that thing could happen to me, so how am I going to overcome. I was having the fear, but by the time I heard people talking about their experiences, the fear just got off."* (participant B, client)

Sharing helped to feel better. Most members encountered that they are not the only one with a problem which improved the wellbeing. The idea that there are others also having a similar problem or even a bigger difficulty, helped them.

> *"Yes, what we shared about the problems made my mind relaxed and then we went when I was happy."* (participant D, client)

> *"Yes, it has changed my behavior and thinking in this way. Before I used to think of you having no problems. But now I know that even you can have problems. Now that I have seen you, I am now getting better."* (participant H, client)

But there were also members who gained nothing from CT and told the members they go back home with nothing.

> *"One weakness was that if we share something here, some people would go home when they have not understood anything. They go back without anything from the group, they didn't pick anything. But we have to continue talking to them. When people are sharing with us, they can just see us like that and they will not accept what we are saying, for example Agines."* (participant D, client)

Evolution

In this category we will discuss an evolution which is seen in the members as well as the facilitators. In the beginning of the research they mostly answered that they needed support from others while at the end you could see that the participants felt stronger and had an urge to help others the way they were helped. They see themselves as healed and want this too for others. They feel strengthened with new knowledge. This evolution can be shown with a case study of participant A as an example:

> *"I started experiencing changes at the beginning of the group up to now. I used to be angry every time and then I came in the group and started sharing with the people and the day that I delivered my problem, is the day that I was set free and up to now I am always happy."*
>
> ...
>
> *"When they were presenting their problems, I thought of sharing with them because I had the experience. For me I thought of them that I had to share with them so that they get better the way I was helped."*
>
> ...
>
> *"For me, I think that the person who presented the topic was having very big problems. That's why she decided to present hers to the group. For me, I had the experience and it is the group that helped me, that's why I decided to help the other friend."*
>
> ...
>
> *"I got to make a lot of new friendships. The benefit that I got was that if someone hurts me, I record what they taught and shared here and I forget and just leave it like that. Another one is that self-reliance, I am relying on my own. I also learned things I used not to know. It has created friendships. The therapy has introduced the people of CCVS to us. I have learned how to stay with friends. I know how to counsel now, I know how to help others."* (participant A, client)

Discussion

The aim of this study was to explore how CT in the North of Uganda is experienced. After analysing the interviews, five themes emerged. In this part, these themes will be interpreted, linked with each other and compared with results of other research. This chapter will form answers on the following three questions:

- How do clients, facilitators and therapist describe CT?
- What do clients, facilitators and therapist experience as helpful?
- Which specific needs do clients, facilitators and therapists describe concerning CT?

These questions were part of the research statement and in the following section, the results of this study will be interpreted with a reflection on these questions.

The relationship between support/coping strategies and consequences

Our findings suggest the fact that aspects of Community Therapy provide **support or coping strategies.** The following elements can be seen as forms of support: the cultural heritage, new knowledge, the group and the outside. This support can lead to **consequences** such as increased self-reliance, the ability to solve problems, and having a feeling of not being the only one. These and other consequences (see analysis) will be discussed in the following part:

The results of the interviews show that using metaphors, singing and dancing during a CT session help the members to feel better. The subtheme called 'cultural heritage' consisted out of dancing, singing local songs and telling metaphors. These original located cultural matters are highly valued and an added value to CT. Arts in general can help individuals to become more in touch with themselves to experience the connectedness between mind and body, using arts in counseling creates an elevation of energy (Gladding, 1992). Client-generated metaphors reflect the unique experience and meaning of a particular individual, the metaphor can incorporate an individual's cultural influences while avoiding broad generalizations and cultural stereotypes (Kopp, 2013). Forms of cultural expression such as the sharing of proverbs, songs and jokes would move the ritual beyond the sharing of individual experience to an experience of unity (Turner, 1969).

Barreto & Grandesso (2010) found that according to the outsider-witness practice of CT, music and songs are very powerful tools in a CT session. When someone shares an experience that awakens the emotions of members, the group thinks of a song that relates to it and they sing it together. In this way, connections are made between people's stories and storylines. Music can be seen as a bridge to verbal approaches in counseling, it connects people and gives them a common denominator where they can relate to (Bonny, 1987; Rosenblatt, 1991).

Many people who have been the victims of abuse, have developed distinct musical forms to provide an outlet for the individual and collective expression of pain (Moreno, 1987). Movement or dance and music are complementary. Moving to music allows the client to express themselves in a way not possible in silence. This self-awareness will have a great impact (Gladding, 1992).

Field notes of the researcher as well as the results of the interviews also described the atmosphere at the end of a session. The members of CT always danced to a song they sang at the end of every session. The description of those moments was mostly about the members who looked happy and proud to sing and dance the local songs. In literature we could find that a primary metaphor for Community Therapy is that of a spider web (Barreto & Grandesso, 2010). According to Nancy Say Kana (oral communication) CT also restores the cultural values of a social group and the social relationships that reinforce and reveal the feelings of belonging to humanity. Culture is like an invisible spider web that unites and integrates people. This is why we can say that the best prevention is to maintain the links of a person with his cultural and relational world, with his web, because it is through his identification with the cultural values of his group that he feeds and builds his identity. The culture for a person is like the web for the spider.

Another type of support, which was analyzed in this research, was the obtained new knowledge by the members. The results showed that the new knowledge they learned, either about topics which returned or about counseling other people, strengthened them; not only to solve current or possible problems but also to have a sense of helping others. The interviewees talked about the new knowledge they learned about the most common themes, which were mostly daily stressors. Information helped to reinforce the members to solve possible or current problems. This even helped their self-reliance. Moreover, the knowledge about counselling that they gained helped their self-esteem and created the thought of them helping others.

Anderson (2007), Madsen (2007, 2009) and Fraenkel (2006) are practitioners who wrote about collaborative approach in psychosocial interventions. They emphasize the priority of client knowledge and perspectives as well as the facilitative aspects of collaboration. This approach involves client autonomy, self-determination and self-agency, promoting the client's self-agency using an egalitarian, non-hierarchical relationship. Madsen (2007) cautions the danger to privilege professional knowledge above client knowledges. It could undermine the client's use of his or her own abilities and strengths (Melito & Rintell, 2013).

Anderson (2012) wrote about a collaborative approach, which strives for the recognition and use of local or insider knowledge: "Local knowledge, such as the expertise, truths, values, habits, narratives and wisdom that is created within a community of ordinary people ... who have first-hand knowledge of themselves and their situation is important." (p. 133). If the local knowledge is formed in a community with the aim to address self-defined needs, it can be relevant, pragmatic and sustainable for that community. If this local knowledge is made significant, the client can feel a sense of participation, belonging, ownership, accountability and responsibility. A successful community experience would result in at least some level of enhanced community competence, a greater sense of control over decision making, and the resolution of at least one identified problem (Israel, 1985).

Roberts and colleagues (1999) state that social support consists of multiple types. On the one hand, there is informational support, the promotion of problem-solving. On the other hand, there is emotional support, the promotion of emotional adjustment or enhanced self-esteem. Many researchers have indicated the combination of those two types to be the optimal matching (e.g., Cohen & McKay, 1984; Cutrona & Russell, 1990). The informational support we can see as the obtained knowledge (see supra), the emotional support as the group.

The interviewees talked about the group as a support mechanism of CT. The group can be seen as the members who are present at a session. Being part of the group creates friendship, togetherness, the feeling of being a member, support of the group and the feeling of helping others according to the respondents. CT is designed to bring people together in order to interact as a network by identifying leaders to engage the community in problem-solving.

To strengthen the supportive network is a second goal. The communality in CT refers to members with a same life-style where there is a sense of identity and belonging, shared values, norms, communication and helping patterns (Israel, 1985). Personal relationships can have a significant impact on individuals' psychological and physical well-being (House, Landis, & Umberson, 1988). To see whether social support is effective, not only quantity matters. The quality of social support defines also the utility (Goldsmith & Fitch, 1997).

As earlier written in the literature, CT can be seen as a form of a self-help group or peer-support. According to Adamsen and Rasmussen (2001), some significant effects can be shown by studies about self-help groups, such as: contact with other people, forming friendships, new behavior patterns, increased self-confidence and the acquisition of new knowledge (e.g. Barlow, Burlingame, Nebeker, & Anderson, 2000; Carroll et al., 2000; Hjemdal, Nilsen, & Seim, 1998; Wituk, Shepherd, Slavich, Warren, & Meissen, 2000). The ideology of self-help comes with the following crucial themes: self-determination, reciprocity, belief in experimental (no expert) knowledge. There is a need for a reference group, there is attachment and identification with others which can strengthen the ego (Riessman & Gartner 1987; Adamsen & Rasmussen, 2001).

Richardson and Goodman (1983) define people in self-help groups as people who have the feeling that they share the same problem and come together as a group to do something about it. According to Matzat (1987, p. 43), "help is produced by the group and then consumed by the group". Adamsen and Rasmussen (2001) found that participation in the group gives individual members new perspectives in life, which creates an improvement of self-perception and a better contact with their network (Gray, Fitch, Davis, & Philips, 1997a; Maisiak, Cain, Yarbo, & Josof, 1981). Being a member of a group gives a positive sense of belonging, solidarity and equality but even a significant amount of emotional and social support (Bennett & Scholler-Jaquish 1995; Gray et al. 1996; Stewart, 1990). Shared confidence of the members and the unconditional acceptance of one another brings the group together and bridges the gap of isolation, plus it gives a feeling of being in control (Bennett & Scholler-Jaquish 1995; Trojan 1989). The sense of belonging to some kind of community is experienced in self-help groups. It also strengthens and develops the sense of normality within a sub-cultural space (Adamsen & Rasmussen, 2001). In a relationship of sharing, peers can experience a feeling acceptance and real empathy (Davidson, Chinman, Kloos, Weingarten, Stayner & Tebes, 1999).

Another type of support or coping strategy which could be derived from the results of the interviews is called 'outside'. This contains the support of the wider environment and religion. If members of CT are supported by their friends, family, neighbors, people who are close to the client but don't attend CT, they feel strengthened. It gives them a boost to join the following session. However, it is also possible that the environment of the member is not supportive to join the session. Praying together was for some of the participants an important aspect of CT which created a coping strategy to forget problems.

The relationship between 'did share' and 'support/coping strategies' & 'consequences'

In a session of CT one or more people present a problem which they are struggling with, afterwards the members share their own experience regarding the presented problem. The results show some reasons why members **would or would not share** in group.

On the one hand, people <u>did share</u> because of the fact that they recognized themselves in someone else's story. Other reasons why people would share are the increased emotions or the case that people were in peace and wanted the other person to be in peace too. According to Rimé and other researchers (1991, 199) experiencing an event which is subjectively emotional significant, is a possible start of social sharing, an interpersonal process. This phenomenon has been the subject of research in the social psychological literature, where it has been observed in individuals; male, female, all ages, across cultures (McCance, Nye, Wang, Jones & Chiu, 2013). White (2007) wrote about a therapeutic technique called 'externalizing the problem'. The aim is to help the clients define their problems as separate from their identities. Sharing experiences of situations which could be seen as unique outcomes, helps the client to internalize personal agency and develop a self-narrative where clients view themselves as powerful (Goffman, 1978; Carr, 1998). Mutual-help groups and organizations are seen as either primarily therapeutic settings or as identity shaping communities (Humphreys & Rappaport, 1994; Mankowski & Rappaport, 1995; Rappaport, 1993).

In this mutual help context, two helping processes are thought to be operative: giving help and support and receiving help and support. Roberts et al. (1999) stated: 'Being the role of helper is itself valuable to members', which is a central statement in mutual help. Riessman (1965) calls this the "helper-therapy principle". According to Riessman (1965, 1976) there is a helper therapy principle in mutual help-groups, where those people who help others indirectly help themselves. Those people benefit from an increased commitment to recovery, the perception of being important to others, their social status and having a sense of independence (Zemore, Kaskutas, Ammon, 2004). There is evidence in general-population surveys of positive associations between helping and psychological health (e.g. lower depression and higher self-esteem; Piliavin 2003).

People who have similar experiences can better relate to one another and thus offer more real empathy and validation (Mead & Macneil, 2006, reflecting on peer support). Peer support can be seen within a wellness model where the focus lies on strengths and recovery, positive aspects of people and the ability to function effectively and supportively (Carter, 2000). Own experiences are used to overcome mental distress and to support others who are struggling with difficulties (Repper & Carter, 2011).

Adamsen and Rasmussen (2001) showed that members are also given the chance to rebuild their self-confidence, their self-esteem and reinforcement of mental strength which will make it possible to deal with issues outside the group. The sharing of common experiences creates identification with other people. Joining people who have to learn to cope with similar problems makes the sense of loneliness and isolation lighter. Therefore, individual problems turn into common problems.

According to Roberts et al. (1999), if members of a group in mutual-help context faced similar problems, the role of informational support is of an important one. The benefits of providing help to others, where the helper has a similar problem as the receiver, have been shown (Gartner & Riessman, 1977; Silverman, 1976). If a helper provides informational support to others, he/she is able to reinforce adaptive strategies to deal with his/her own problems and see those more objectively. This could be linked to an increased feeling of competence and social usefulness. These feelings could even improve the social and interpersonal functioning in other life domains.

Forchuk, Martin, Chan & Jensen (2005) found that receivers of peer support, improved on giving social support, their social skills and social functioning. According to Kurtz (1990), people who engage in peer support see different perspectives and successful role models. Those people can share problem-solving and coping skills which could be the reason of improved social functioning (Repper & Carter, 2011). Yalom (1970, 1975) did research on change processes in group therapy and found the influential theory. In this theory altruism is seen as a sense of having helped group members via sharing and giving which is a curative factor (Zemore et al., 2004). An interesting finding was the fact that members do feel relieved that they are not the only one struggling. It even strengthens the person to realize that he/she had overcome the problem and, in this way, could help another person.

Relationship between 'did not share' and 'rules and practicalities of CT'

On the other hand, there are multiple reasons why participants <u>would not share</u>. Most of those reasons can be linked with the **rules and practicalities of CT**.

An important reason why people would not share in a CT session is fear. The fear to share mostly held the participants back, either because of the lack of confidentiality or either because of the reaction to advice giving. Since it was already said, the emotions were too high or the person concerning is also there, are other motives to not share.
According to Morrison, Wheeler-Smith and Kamdar (2011), a group is effective when members share their knowledge and speak up. Some characteristics are interdependence, shared responsibility, diffuse expertise and divergent perspectives (Mesmer-Magnus & DeChurch, 2009; Nemeth et al., 2001). Research has shown that group members not always share their opinions, ideas and concerns. We can call this an absence of voice which could cause negative implications for the group (e.g., Argyris, 1991; Janis, 1972; Perlow & Williams, 2003).

When members of CT don't abide with the rule of <u>confidentiality</u>, trust is hard to find. This causes fear to open up to the group. In this way a possible explanation why people would not share is fear. Fear of the fact that their secrets are not safe or fear to make mistakes and to be corrected by the facilitator and therapist.

Mostly, the feeling of safety will lead to speaking up in a group. To open your voice in a group is connected with the belief of being safe, which can be related to psychological safety, this means whether a person could take an interpersonal risk in a particular context (Edmondson, 1999; Morrison et al., 2011).

A possible explanation why people would rather not share is because of the lack of trust. Trust to open up to people they don't really know yet, or trust to open up to people who could spread the rather sensitive information about someone else. As already stated, in CT people share their own problems and knowledge. The group is not fixed and, in this way, the members can go or not go by their own wish. The members of a session can differ each session since the openness of CT. Therefore, the trust building can take some time and is a continuous process of the facilitators and therapists. Furthermore the rule of confidentiality was sometimes broken during the research and some participants gave this as reason of not opening up to the group.

Another reason why members would not share was because of the <u>constitution of the group.</u> The fact that a client's problems/struggles/experiences had to do something with another member who was attending the session. In this way it was sometimes hard according to the interviewees to talk freely about what or who was bothering them since too many people were involved who were also listening.

A rule of CT is that people <u>can't give advice;</u> it is only about sharing of own experiences. Concerning this guideline there was a lot of confusion. The facilitators and therapists had to raise the awareness about this advice giving and stop the members. This led to fear to open up to the group. Advice can be seen as a form of help. But receiving help is not undoubtedly helpful. There is a potential threat, if people give advice in disguise of helping someone, to the self-esteem of the receiver which could lead to the feeling of being failed, inferiority and dependency (Fisher et al., 1982). According to Goldsmith and Fitch (1997) research has shown that the perceived helpfulness of advice depends on the expertise of the person who gives advice, or if the advisers first listen instead of responding immediately. It could also cause imposition and intrusion if someone claims what the other person should or shouldn't do, which threatens the perception of self-worth and/or the autonomy of the receiver. This is why advice ought not to be given in CT and the therapists and facilitators tried to stop members who were giving advice. This actually created fear to speak up, to make mistakes and to disappoint the facilitators and therapists, according to the respondents.

Evolution

Looking at the relationships between the themes, a trend was found. Since the interviews took place consequently over a period of five months, an evolution of the participants could be seen. A member comes to CT to open up about struggling events in his/her life. The group shares with this member how they experienced something similar and how they overcame their problem. The member who opened up feels strengthened with the knowledge he/she obtained. Over time this member shares his/her own experiences with others who open up to the group with their problems. In this way the member feels strengthened with the thought of helping others. Additionally, the thought of not being the only one helps to forgive and forget his/her own problems. While metaphors, songs and proverbs help the member with staying connected with their own culture and creating happiness in their lives since there is togetherness.

Limitations

While the results in this study do reveal relevant findings regarding the experience/impact of CT, several limitations of the study must be taken into account. This research has some limitations which should be considered with the interpretation of the results and conclusions.

At first, there are some limitations according the composition and size of the research group. In this research only two communities were followed, and of those communities, only two therapists, two facilitators and six clients were interviewed.

Due to this rather small group, the conclusions of this research are limited to just a part of the population. We have to interpret the results very carefully and we can't generalize (Maso & Smaling, 2004). It is noteworthy that while a therapy focused on a specific population such as the northern Ugandan population, with a low socio-economic status, which was the target of this study, therapy developers should be careful in generalizing the findings to all populations. The social and contextual factors of a society can have an influence on the operation of a therapy program (De Mey & Vandenbroeck, 2014) In addition, the research group counts only 1 male, thus the sample is not representative with the population. Gender is moreover an influencing factor for the experience of stress, which can have an influence on the experience of CT and the results (Derluyn & Broekaert, 2007a; Kohli & Mather, 2003).

The interpretation and analysis of the qualitative data could be influenced by cultural bias. Since the semi-structured interviews were reviewed by Ugandan therapists, an interpreter, a Congolese and a Belgian researcher, final alterations were made possible. These people helped to give additional information on some culturally sensitive subjects to diminish cultural bias.

Another limitation relates to the communication barrier between the respondents and the researcher. There was a translator present who could misinterpret in both ways. Some questions or western concepts could be misunderstood because some concepts are not existing in some cultures (Derluyn, Broekaert & Schuyten, 2008; Kohli & Mather, 2003).

The researcher tried to take this into account through assuring the respondents to ask information or questions at any time. Additionally, statements were reversed to the respondents and extra questions were asked to control and deepen the data. It is also very likely that information got lost during the interviews, because of the fact that there was a process of continuous interpretation between Luo and English. In order to avoid misinterpretations at this stage, the interview protocol was reviewed step by step with the interpreter to develop a common understanding.

The explorative and small-scale nature of the research cause that there is little to tell about the perspectives of the therapist in other services (Maso & Smaling, 1998). However generalizing was not the aim, it is still important to emphasize it. At the same time, this limitation is also a strength of this research. The specific input of this research creates the fact that there could be worked with a concrete question from the working field which leads to recommendations for the involved service. But the inclusion of more therapists and therapists of other services could have reinforced the research.

Another limitation is the fact that the research took place at a moment where CT was recently being implemented in the working of CCVS-Uganda. Which could have an impact in this way: since the therapists and the facilitators were searching for the right way to conduct this new kind of therapy. Furthermore, as to the interpretation of the results, it is important to notice that the interviews were only a snapshot; therefore the results could be influenced by the mood of the respondent at that moment. There was also only one researcher responsible for conducting the interviews and processing of the results. This could lead to a possible distortion (Maso & Smaling, 2004). Methodical triangulation could oppose this, but there was only the use of just one measure-instrument, the semi-structured interview (ibid.). The researcher took this into account during the process by using a reflexive attitude and guaranteeing feedback of the results to the involved actors (Wardekker, 2000).

As written earlier, the nature and the setting of the research could impede the participants to speak freely and therefore he/she could give socially desirable answers (Derluyn, 2005; Janssens, 1985). There was an attempt to decrease the socially desirable answers by guaranteeing anonymity and by minimalizing suggestive questions (Janssens, 1985; Mortelmans, 2011). Although this qualitative approach gave a possibility to have a broad perspective, we need to be cautious with the outcomes since the respondents were participants of the research on a free basis and kept going to the therapy. These conditions are signs of being involved with CT. In this way the answers of the respondents could be biased in a positive way. The respondents in this study were completely free to participate, which suggests that these participants were motivated to begin with.

Finally, another side note about the literature, firstly about the amount and secondly about the actuality of the scientific resources. In this way literature about CT was hard to find and concepts connected with CT were rather outdated and thus old. Furthermore, the results which occur in scientific research are mostly found in other countries. Since CT can differ a lot in each organization and country, the comparison of results should be cautious.

Suggestions research/recommendations

Implications for scientific research

Based on the description above, recommendations could be formed for future research. The existing literature on CT proves that only a few studies had their focus on ethnic minority populations (e.g. in Brazil). Therefore, more research is needed that explore the impact of CT in a different context and which also puts its focus on other (minority) populations.

In the literature it appears that following therapy, is a process whereby a person is going through an evolution (Ryan & Deci, 2000; Van Regenmortel, 2008;2009). This process is a longitudinal one but the research period is rather short, and therefore is it hard to see big evolutions. Longitudinal research would map the experiences of CT better (Ní Raghallaigh & Gilligan, 2010). Furthermore, a recommendation is made to combine qualitative and quantitative research methods to increase the validity of the research (Maso & Smaling, 2004). In this research semi-structured interviews were used, a qualitative method; an extension of methods in scientific research (e.g. survey, focus groups) though, could give a more detailed and correct image of CT.

Another interesting implication for scientific research is to research the Community Therapy after the handover of the therapists. There is a need for a thorough study regarding the independence of CT with only the local actors (clients and facilitators). But also the effectivity of CT on the well-being of members could be investigated, in order to strengthen the working of the therapy. In this way a follow-up study should be organized. CT has the aim to strengthen the community members, through training local facilitators in order to keep sustainability. In this way, it could be interesting to conduct a comparing research to see changes before and after the therapy. And what kind of impact it had on someone's life.

As described earlier, the composition of the research group had some limitations. The sample survey almost only included women, this is why a comparing research with a varied sample could be interesting. How is CT experienced with men, or with women? Or it could give a broader view on the diversity within these experiences.

Finally, a last recommendation could be to study the diversity and characteristics of the differing communities. As described in the methodology, the two communities have differences, for example the location or the history, which could possibly have an influence on the results. Further research could be made to see whether the location has an influence on the way CT is experienced.

Implications for policy and practice

In the interviews and during this process of analyzing and interpreting, some recommendations and implications for policy and practice arose.

The first question of all the respondents was to expand CT to other communities. With this question, they asked to install this sort of therapy in other communities as well since people are benefitting from CT. The respondents also asked to continue for a longer time, where they emphasized the importance of strengthening the facilitators enough before handing over the groups to the community-based facilitators.
According to Amone-P'Olak (2005) there is a need to focus on recovery of hope for a better future in psychosocial interventions. In this way, sustainability is an important condition of such programs. Another implication is linked to the one mentioned above. The therapists as well as the facilitators asked for more training on CT, to be more grounded. Also, they suggested to lengthen the period of supervision and to give useful feedback. As well as a continuous follow-up, even after the handover.

Another implication for policy and practice is about confidentiality. Since the confidentiality was sometimes hard to find, and the process of trust building took some time because of the openness of the therapy, some respondents proposed to have a closed group to work with. Although this could also be contradicted by the fact that multiple respondents acknowledged the benefits of the openness of CT. Therefore, there is a need to continuously repeat the rule about confidentiality and stress the importance of it. In one community they worked with a rule to counter the advice giving. If a member would start to give advice and other members would hear it, they could stop that member by forming a cross with their hands. This way of guarding the rule, in a peaceful way, of giving no advice could help in other communities as well.

In the group there were mostly women, the one male and other respondents had a wish to involve more men, since it is good to look at the whole community and since they tell themselves that a bigger involvement creates a better cooperation.

Conclusion

In 2006 approximately, the LRA left the North of Uganda. Since then, there is a war to peace transition. In Lira, a post-conflict context, attention must be given to past traumatic experiences and current stressors in psychosocial interventions. Sustainability, participation in community and social support are mechanisms which promote the psychosocial well-being and which are found in Community Therapy.

This type of therapy was facilitated by CCVS-Uganda in several communities. In this research, therapists, facilitators and clients were interviewed for multiple times about CT sessions.

The several results were analyzed and interpreted. According to the interviewees, there are some aspects of CT which work as coping strategies/support. The cultural heritage such as proverbs, songs, etc. but also new obtained knowledge, the group and support outside such as religion or wider environment are support mechanisms of CT. Those coping strategies give members of CT a feeling of increased self-reliance, having the ability to solve problems and not being alone.

Other findings which occurred during the analysis was the fact that people mostly shared because they wanted to help other people and didn't share because of the rules and practicalities of CT. The fact that there was no confidentiality, or the person concerning the problem was also there or the fear to the reaction of advice giving were reasons not to open up to the group.

Further research is needed to deepen the knowledge about CT, to look at different perspectives and confirm the analyzed results as stated above, of Community Therapy.

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Content of appendices

A. Informed consent

GHENT UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH STUDY UNIVERSITY OF GHENT (BELGIUM) AND CCVS-UGANDA

Title of study: How is community therapy experienced in Lira, Uganda?

Researcher – student : Aagje Rottiers

Introduction

You are kindly asked to be part of a research study involving counseling practices in Lira District. The reason for this request is your position within the community and your affiliation with CCVS counseling practices. Please read this form carefully and ask any further questions you might have.

Purpose of research study

The purpose of this study is to come to a better understanding community therapy, a mental health support service which CCVS Lira provides. This will be done by answering the following research question: how is a community therapy experienced? During this interview I would like to ask you some questions about how you experienced the therapy, to what extent this therapy had an impact on your perspective on mental health and how it has influenced your daily life. The aim of this study is to explore themes or stories that people share towards the program, in order to improve further implementation/deepen the knowledge about community therapy. The research study will ultimately be presented as a master thesis at University of Ghent.

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Procedure

If you agree to be part of the study, you will be asked to engage in some interviews, conducted by the researcher. Each interview will consist of a set of questions. If the participant wishes to add to the interview by sharing experiences not directly related to the set of questions, the participant is free to do so. The length of the interview is not decided beforehand and will depend on how much the participants want to share. An interpreter will be present to translate and interpret between Luo and English.

Payment

No payment is made available for your participation in this study.

Confidentiality

The records of this study will be kept strictly confidential. The data collected during the research will be kept in a secured place and the electronic data will be coded and secured and your identity will not be disclosed in the final product of the master thesis. For practical reasons this interview will be taped. However, it is your choice if you want this or not. The tape is for personal use only and will not be shared with anyone.

Right to refuse or withdraw

You have the right to refuse to be part of the study and you also have the right to withdraw from the study at any time. The participant does not have to answer any single question if he/she does not want to. The participation in this research is thus completely voluntary.

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Questions or concerns

Please contact the researcher, Aagje Rottiers, by using telephone number 0787019097 in case of any questions or concerns. If the researcher is not able to give a satisfiable answer, please contact Centre for Children in Vulnerable Situations, CCVS, by using telephone number 078 200 1320.

Consent

If you are willing to participate in this research study, please provide your signature below. Your signature indicates that you are voluntarily engaging in this study and have read and understood the information provided above.

Thank you for your cooperation in advance.

Participant's Name _____

Participants's Signature   Date:

Researcher's Signature   Date:

B. Intake clients & facilitators

General information

Sex: male/female

Profession: □ Student: □ Work: □ Other:

Age:

Current status: □ Married □ Single parent □ Cohabiting □ Other:

How many children do you have (+ age)? ...

Kinship towards household members: □ Mother □ Father □ Guardian □ Sibling (brother/sister) □ Other:

What is your address/locality/village?

Personal background

Are there particular things in the past or now which cause suffering for you? Can you tell me more about them?

Community therapy in general

How or where did you first hear about community therapy?

In what way do you find it necessary to attend a community therapy?

What were your expectations in the beginning, when you first attended CT?

Those expectations, are they met? Or just for a part or not at all?

Is there a reason why you don't attend a community therapy sometimes, which one(s)?

What does community therapy mean for you?

Having attended community therapy, what benefits did you encounter?

What do you think about the composition of the group, the heterogeneity? (younger/older, women/men?)

Having attended community therapy, what do you consider to be the disadvantages? Did you experience any disadvantages?

Do you think this kind of therapy had any impact on your environment/community as well? For example, in what way could your children experience any changes and how did they sensed the impact?

Start date of your first community therapy:

How many times did you already attend a community therapy:

Future program recommendations

What do you consider to be the strengths of community therapy?

What do you consider to be the needs with regard to future improvement for the therapy?

Do you think this project CT has to be enlarged to other territories or communities of Uganda? Why?

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General information

Sex: male/female

Profession: □ Student: □ Work: □ Other:

Age:

Current status: □ Married □ Single parent □ Cohabiting □ Other:

How many years working in CCVS:

Community therapy in general

How or where did you first hear about community therapy?

In what way do you find it necessary to provide community therapy?

Do you believe that CT is an approach which is realistically adapted to the communities of Lira and Uganda in general?

Is there a reason why community therapy doesn't take place, which one(s)?

What does community therapy mean for you?

Having attended community therapy, what benefits did you encounter?

Having attended community therapy, what do you consider to be the disadvantages? Did you experience any disadvantages?

In what way do you think community therapy differs from other mental health support CCVS provides?

Are there any difficulties/challenges in being a community therapist? Which ones?

Start date of your first community therapy:

How many times did you already attend a community therapy:

Future program recommendations

What do you consider to be the strengths of community therapy?

What do you consider to be the needs with regard to future improvement for the therapy?

D. Semi-structured interview clients & facilitators

Attendance

What made you consider to attend this community therapy?

Content

Which themes were the topics? Among them, which one did touch you the most and why?

Were there moments which were difficult for you during the sharing?

Which metaphors/songs were used or sang? How did you feel after they were said? Did you have the feeling it helped you, in what way?

Did many people give advice? What did the facilitator do about it?

Do you have the feeling this therapy has learned you something? Can you tell me what?

Group interactions

Do you know all the people who attended the therapy personally?

Do you trust the group?

Did many people share their experiences?

To what extent are these contacts/friendships supportive to you? In what way do you find it supportive/helpful?

How do you experience it yourself to share? Are there reasons which make it easier or more difficult?

What did you think about the person who presented the topic?

Did you also present a subject to the group? Which one?

How was your relationship with the facilitator and/or therapist?

Is there a difference for you between the facilitator and the therapist? Can you elaborate on this idea?

I would like you to think about the people that are close to you (for example, family members or neighbors), how do you think they feel about (perceived) the fact that you participated in this community therapy session?

In what way did this therapy create open doors to discuss several concepts with family members, neighbors?

Do you think that CT has changed relations among the group members? How?

Has there been change due to CT in the community?

Personal impact

Do you have the feeling this session helped you personally? In what way?

Have you gained new valuable insights after this session? Which one(s)?

Do you feel that you comprehend your own behavior/thinking in a different way than before you attended this community therapy?

Closing stage

How do you feel about this interview? Is there anything else you want to share with us?

E. Semi-structured interviews therapists

Which topics were being discussed this therapy? Were you touched by it?

Did this session give you new insights personally/professionally?

Can you describe the group cohesion?

Was there a lot of sharing?

Did you have to remind the 'rules' of community therapy to the clients? Were there many people who gave advice and how did you address this?

F. Follow-up interview clients & facilitators

Having attended community therapy for several times, what benefits did you encounter?

Having attended community therapy for several times, what disadvantages did you encounter?

Looking back at community therapy, what for meaning has this therapy for you?

What do you consider the strengths of community therapy?

What do you consider the weaknesses of community therapy?

What do you recommend for future changes regarding the needs of community therapy?

Which themes do you still remember and have had a big impact on you?

Do you still have topics where you would like to share or present?

What has been happening after CCVS has withdrawn?

Do you think that CT has changed relations among the group members? How?

Do you thing that CT has changed your broader environment, family, neighbors, children? And the whole community of AM/BA?

As a facilitator, how do you see the future regarding CT?

Can you see a difference in yourself at the start compared to the end of CT? Can you see changes in yourself during the time of CT? What changed and when?

G. Follow-up interview therapists

Having attended community therapy for several times, what benefits did you encounter?

Having attended community therapy for several times, what disadvantages did you encounter?

Looking back at community therapy, what for meaning has this therapy for you?

What do you consider the strengths of community therapy?

What do you consider the weaknesses of community therapy?

What do you recommend for future changes regarding the needs of community therapy?

Which themes do you still remember and have had a big impact on you?

What has been happening after CCVS has withdrawn?

As a therapist, how do you see the future regarding CT?

Can you see a difference in yourself at the start compared to the end of CT?

H. Tree structure Nvivo

Community therapy	Rules & Practicalities	Constitution	
		timemanagement	
		confidentiality	
		advice giving	
		needs	financial support therapist training
		future	
		extra	mobilization other program no CT
	Themes	alcohol	
		business	
		farming	
		illness	
		in-laws	
		loss	
		neighbours	
		pain	
		schoolfees	
		violence	
	Copingstrategies/support	culture part	
		new knowledge	
		outside	environment religion support outside CT
		group	friendship & toegetherness support of others helping others members
	Sharing	fear	
		experience	
		already said	
		trust	
		emotions	
		person concerning is there	
		extra	no respect sharing because feeling ok sharing of someone else also helped me
	Consequences	positive changes in self	
		forgive & forget	
		helps possible problems	
		persevering	
		going back with nothing	
		solve problems	
		sustainability	
		sharing helped to feel better	
		taking action	

I. Nederlandstalige samenvatting

Toen de 'Lord's Resistance Army' Oeganda verliet in 2006, werden een groot aantal psychosociale interventies ontwikkeld om het welzijn te verhogen van mensen die betrokken waren door de oorlog. In Lira, Noord Oeganda, een 'post-conflict' gebied, is de nood voor psychosociale interventies hoog. Deze interventies dienen te streven naar duurzaamheid, toegankelijkheid voor iedereen en focus op zowel trauma als dagelijkse stressoren. Onderzoek naar Community Therapy (CT), een psychosociale interventie die
is opgericht door Adalberto Barreto, is beperkt. CT is recent geïmplementeerd in CCVS-Uganda en voldoet aan de eisen vooraf beschreven. Deze studie onderzoekt de ervaringen van mensen die CT sessies bijwoonden in twee gemeenschappen in het district van Lira.
Een kwalitative methode is gehanteerd om tot een dieper verstaan te komen van de ervaringen. Tien participanten, bestaande uit cliënten, faciliteerders en therapeuten van twee gemeenschappen, werden geïnterviewd voor vijf keer over een periode van vijf maanden. Na de intake, werden er drie interviews afgenomen telkens over een CT sessie en na twee maanden werd er een follow-up interview afgenomen. De resultaten van deze interviews
werden geanalyseerd a.d.h.v. een systematische analyse via de Nvivo-software. De resultaten zijn opgedeeld in vijf thema's (Praktische aangelegenheden, Steun mechanismen, Delen, Gevolgen, & Evolutie) met elk enkele subthema's.
De resultaten tonen aan dat sommige aspecten van CT werken als steun of copingsstrategie. Deze aspecten zijn cultureel erfgoed, nieuw verworven kennis, de groep en steun van buitenaf. Deze steunmechanismen blijken de leden van CT een verhoogde zelfwaarde te bezorgen alsook de capaciteit om problemen op te lossen en het gevoel te geven niet de enige te zijn. Andere resultaten geven redenen aan waarom leden wel of niet zouden delen tijden een CT sessie. De respondenten die deelden hadden een gevoel om anderen te helpen terwijl de respondenten die stil bleven was vooral uit gebrek aan geheimhouding, de regel om geen advies te geven of aangezien de persoon die het probleem betrof ook aanwezig was. Deze bevindingen impliceren verder onderzoek over Community Therapy en een kijk naar de praktische kant voor een betere werking van CT.