THE MEANING OF TRUST IN SOCIO THERAPY:
A CASE STUDY OF TRAUMATIZED REFUGEES IN
THE NETHERLANDS.

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ABSTRACT

This study examines the experience of refugees who are participating in sociotherapy program in two psychiatric clinics, Equator and De Vonk Noordwijkerhout in the Netherlands. The main focus of the study is to understand the meaning refugees give to trust, which is considered a key aspect of sociotherapy.

In the last several years the Netherlands has moved away from its traditionally protective stance towards asylum seekers to take up a rather restrictive approach that now stands out among Western European countries (Van Stokrom 2003:1). Conscious of a densely populated country and hostile public attitude towards immigrants and possible manipulation by economic immigrants, the government has made the process of asylum application long and difficult. Consequently, genuine refugees who are running away from political violence are faced with these strict policies and become more traumatized and more wary.

Notwithstanding the current strict immigration policies in the Netherlands, there are facilities and programs that help refugees to deal with life in their new country. Sociotherapy is one of the services offered to refugees in two Dutch clinics and is meant to help refugees rehabilitate and rediscover ordinary life through creating and developing dynamic relationships and trust is perceived as an essential and ‘existential’ aspect of a dynamic relationship.

This study was motivated by my experience with a community based sociotherapy program in the Northern province of Rwanda. Sociotherapy was introduced in Rwanda to help Rwandans heal from past traumatic experiences of war and genocide, and build new interpersonal relationships on the basis of mutual trust. Similarly, refugees in the Netherlands have experienced various forms of political violence and often suffer from traumatic experiences. Therefore this study is not only exploratory and descriptive but also a comparative study between the Rwandan experience of sociotherapy and the Dutch experience of sociotherapy.
A revision of other studies led to the formulation of questions that helped the investigation. Data collection included participant observation of sociotherapy proceedings in the two clinics and informal and formal interviews with refugees, sociotherapists, GP and psychiatrists. The analysis and interpretation of what trust means to refugees who are experiencing sociotherapy was done using three theoretical concepts; control, agency and power. This study establishes that the meaning refugees give to trust can be understood in the light of what is important in the lives of refugees; namely story telling and expectations.
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ABBREVIATIONS

AC: Aanmeld Centrum
AMC: Amsterdam Medical Center
AZC: Asiel Zoekers Centrum
FAR: Forces Armées Rwandaises
GP: General practitioner
HIV/AIDS: HIV stands for Human Immunodeficiency Virus; AIDS stands for Acquired Immune Deficiency Syndrome.
HRW: Human Rights Watch
IND: Immigratie- en Naturalisatiedienst
MOA: Medische Opvang Asielzoekers
OC: Onderzoek Centrum
PSM: Patient-Staff-Meeting
PTSD: Post Traumatic Stress Disorder
PTSS: Post Traumatic Stress Syndrome
RPF: Rwanda Patriotic Front
TV: Television
UNHCR: United Nations Haut Commissariat For refugees
CHAPTER ONE

BACKGROUND

1.1. Introduction

This study is about investigating the meaning refugees who are experiencing sociotherapy in the Netherlands, give to trust. This chapter aims to give a description of the background and execution of this study as well as the methodology. The objectives and research questions were used as guide for the study. The chapter also highlights the personal motivations of the researcher. Literature was surveyed from various sources in order to obtain a clearer understanding of sociotherapy, refugeehood and trust. Moreover this chapter highlights the challenges of this study and how they were reflected in previous studies.

1.2. Background and motivation of the study.

This thesis focuses on the meaning refugees who are experiencing sociotherapy in two psychiatric clinics in the Netherlands give to trust. My interest to study sociotherapy and trust was based on my participation in the introduction and implementation of a community based sociotherapy program in the Northern Province of Rwanda in 2005. I was intrigued to learn how sociotherapy is practiced here in the Netherlands, where the Rwanda program originated.

The focus of this study is not on the method of sociotherapy as such, but rather on what trust means to refugees who are experiencing sociotherapy. In an attempt to understand this meaning this study considers what is at stake as far refugeehood is concerned, refugees' lives in the Netherlands, and refugees' interactions with sociotherapists in the clinic. The latter focus is relevant due to the fact that sociotherapy, is a group therapy that hinges on human interactions. As Whiteley (2004: 244) remarks, "the daily community meeting is a primary focus of interaction for observation of, and intervention within, the field of sociotherapy."
However before we get into further details, it is important to understand what sociotherapy is. In the “Professional profile of sociotherapists”, sociotherapy is described as:

“the methodical management of the living environment of a group of clients, directed towards reaching the treatment targets of this group and conceived as a means of achieving the treatment targets of the individual client within a functional unit, usually in a clinical treatment setting” (Foundation Centrum’ 45 2008).

In this respect, the perception of trust in this study is two fold. On the one hand trust is perceived as an essential and ‘existential’ dimension of human relationships (Flores and Solomon 1998:219), that is created and builds up through human interactions taking place in sociotherapy. On the other hand sociotherapy is perceived as a goal of sociotherapy, in terms of the expectations refugees set in sociotherapy.

The motivation for this study is mainly personal.

My involvement in the implementation of sociotherapy in the previous District of Byumba¹ in the North country province of Rwanda motivated me to do this study in the Netherlands. Sociotherapy in Rwanda is implemented in a totally different context and population compared to the Netherlands. A fundamental difference is that people who are benefiting from sociotherapy in Rwanda are all Rwandans who in one way or another are facing problems that can be considered a legacy of the Rwandan conflict of the early nineties. In the Netherlands, sociotherapy beneficiaries are generally refugees from various countries and who have suffered from a range of political violence in their country of origin.

The conflict in Rwanda started in 1990 when a civil war broke out between the Rwanda Patriotic Front (RPF) and the Forces Armées Rwandaises (FAR²) and reached a climax in April 1994 with the genocide of the Tutsi people. Besides horrific massacres and other forms of traumatic events, the genocide and civil war also resulted in broken social and interpersonal relations due to the population’s loss of trust in one another. It is widely believed that most (if not all) Rwandans should participate in sociotherapy program given the many traumas related to the political conflict of the event.

¹ When the program started the District was Byumba but recently it has been given a new name, Gicumbi. In this study I will keep the name the program started with.

² Forces Armées Rwandaises (Rwandan Armed Forces).
However, there are those who stand out as most affected by the consequences of the genocide and civil war; namely genocide survivors, widows, orphans, single mothers people living with HIV/AIDS, and ex-prisoners.

When sociotherapy was introduced in Rwanda in 2005, I first joined in as a translator for a Dutch sociotherapist and trainer who was training the locals to become sociotherapists. At the end of 2006 I shifted my role to an observer and documenter with a view of monitoring activities that take place in sociotherapy groups. In order to be more effective I chose one group, ex-prisoners, and followed them for a period of six months from January 2007 to June 2007. The group was comprised of nine ex-prisoners and two sociotherapists. We met regularly, every Monday morning from 9 to 12 in a public hall. I listened, observed and participated in the discussions that took place in the sociotherapy group. I include my personal experience not only to make the study a comparative one between the Rwandan and Dutch experience with sociotherapy but also to elucidate further my personal motivation in doing this research.

It is important to note that ex-prisoners or prisoners are by no means a new phenomenon in Rwanda. However, the genocide has given a new dimension to being an ex-prisoner. Shortly after the genocide, Rwanda experienced wide-spread arrests of alleged perpetrators. As a result, Rwanda witnessed overcrowded prisons, with approximately 120,000 detainees (www.inkiko-gacaca.gov.rw) and thousands of ex-prisoners.

According to the ex-prisoners in the group I was following it did not matter for what reason one went to prison after 1994. People always assumed that one went to prison because he/she had participated in the genocide. Consequently, he/she is a (umwicanyi), “killer” (igikoko) “an animal”. Ex-prisoners think that no one trusts them. On the other hand, the ex-prisoners told us that they only trust ex-prisoners because those are the only people who can understand what another ex-prisoner is going through.

According to sociotherapists who have worked with ex-prisoners in Rwanda, the latter desperately need people to trust them if they are to return to a normal life in society after their imprisonment. (Focus group discussion with sociotherapists, Byumba-Rwanda July 19, 2007). In this respect sociotherapists and ex-prisoners both agree that sociotherapy helps the latter to (re)create trust through discussions and activities that take place in sociotherapy groups (such
as sharing drinks and food, praying together, building houses for one another, home visits etcetera).

In addition, ex-prisoners appreciate their relationships with sociotherapists, the place where the meeting takes place, and the reactions of other people who know and see ex-prisoners participating in sociotherapy.

The ex-prisoners believe that the six months they spent meeting, discussing and sharing activities with sociotherapists (who were not ex-prisoners) was an indication that they, as ex-prisoners, could be trusted again. This became more evident following sociotherapists’ visits to the ex-prisoners’ homes. After the visits the ex-prisoners told us that their spouses and even some of their neighbors told them that our visit was an indication that people can trust them again. In this respect, for ex-prisoners trust means renewing interactions with non ex-prisoners or the rest of the society. In the light of what trust means to ex-prisoners in the Rwandan context of sociotherapy this study sought to understand what trust means to refugees who are participating in sociotherapy in the Netherlands.

In the Netherlands, among participants in sociotherapy are refugees who “have serious traumatic experiences and come from many different countries”. (http://www.centrum45.nl/vonk/ukvclin5.htm#socio 29 Ap. 2008). Suffering from traumatic experiences “caused by persecution, war or violence” refugees mistrust not only people but also institutions (http://www.centrum45.nl/ukindrfa.php 29 Ap. 2008). As Miller and Rasco (2004:13) observe, “violent conflict, particularly when accompanied by the propagation of ethnic or religious stereotypes, often fosters attitudes of distrust and hostility, and can destroy previously supportive social relations and undermine faith in social institutions and organizations”.

In Rwanda, sociotherapy is not practiced in only one specific milieu. The context of Rwanda offers flexibility and responsibility to parties involved. This means that sociotherapists and beneficiaries work together to find a place that is suitable, convenient and conducive for the sociotherapy process. Therefore, in Rwanda sociotherapy meetings are often held in school halls, church halls, offices, in private sitting rooms, under trees, and in open air. Moreover in Rwanda activities and relationships that are initiated in group sociotherapy extend beyond the original 15 session time frame. In most groups members continue to meet, in associations they created during sociotherapy (with advice from the sociotherapists) for income generating
activities. In other words sociotherapists work outside the groups to help beneficiaries take on the challenges of every day life in the Rwandan society.

In the Netherlands, contrary to the Rwandan context, sociotherapy is performed exclusively in hospital settings. The question is what do sociotherapists do to help refugees deal with life challenges here in the Netherlands beyond the clinic settings?

This study explores what the milieu of the hospital means to the approach of sociotherapy here in the Netherlands in general and how it impacts on the meaning clients give to trust in particular. Furthermore this study seeks to understand in what ways the whole idea of being a refugee in a clinic and participating in sociotherapy influence the meaning refugees give to trust. In addition to the above mentioned contrast on the place and categories of people who are experiencing sociotherapy both here in the Netherlands and in Rwanda, this study also raises questions about the influence of the milieu and category of beneficiaries on relationships between sociotherapists and refugees.

1.3. Research objectives and research questions

1.3.1. Main objectives

a) To explore refugees’ experiences of sociotherapy in psychiatric clinics in the Netherlands and the meaning refugees give to trust as a key aspect of sociotherapy.

b) To make a comparison between the Rwandan experience of sociotherapy and the Dutch experience of sociotherapy.

1.3.2. Main Study question

How do sociotherapists conceive of trust, and what meaning do refugees who are participating in sociotherapy in psychiatric clinics in the Netherlands give to trust? How do both perspectives compare with each other?

1.3.3. Sub-questions

1. What are the experiences of refugees in sociotherapy? What are their expectations?

2. What is the role of trust in sociotherapy for refugees?

3. What does trust mean for refugees who experience sociotherapy?
4. What are challenges do sociotherapists face while helping refugees (from different backgrounds) have trust in people and institutions?

5. In what ways do cultural differences influence the meaning refugees give to trust?

6. How does the meaning refugees give to trust differ from the meaning trust has for health care staff?

7. How do sociotherapists influence the meaning refugees give to trust?

8. How does the hospital setting influence the meaning refugees give to trust?

9. How does the hospital milieu influence power relations between refugees and sociotherapists?

10. In what ways is sociotherapy in Rwanda different from sociotherapy in the Netherlands?

1.4. Literature review

There is substantial literature on the subjects of sociotherapy, refugees and trust. A survey of key literature provides both insights and challenges to this study. The reviewed literature on sociotherapy traces the origins and the development of sociotherapy method. Using my personal experiences I comment on points highlighted in the literature review and raise questions regarding the focus of this study.

1.4.1. Sociotherapy: Origins and development

Sociotherapy originates in a therapeutic community approach. This approach as we know it today is commonly believed to have originated from the United Kingdom during the Second World War. Some scholars, however argue that the idea of using the community as a healing space for mentally ill people may not be new per se but “is probably universal and as old as society itself” (Kennard 2004: 304). Whitely (2004: 233) argues that similar methods to sociotherapy were used in other parts of Europe long before sociotherapy became established as therapy method for mentally ill people. Among these antecedents of sociotherapy is Philippe Pinel in France in 1792 who is said to have cut chains and set free insane inmates in Bicêtre and Salpêtrière asylums in Paris, thus pioneering methods of humanly dealing with mentally disabled people.
Whiteley (2004) notes that England had a similar revolution in 1792 when a family of merchants (the Tuke family) set out to build a hospital for mentally ill people based on the humanitarian principles of respect, comfortable living and friendly relationships for patients. The methods initiated by the Tukes family were known as moral treatment. (Italics in the original). Although it was taken from a translation of Pinel’s treatise, it differed from Pinel’s traitement morale (Italics in the original) on the grounds that the latter was “through the emotional self” while the former emphasized “the attitude of respect for human rights and values of relationships” (Whitely 2004: 234).

Whiteley (2004: 235) highlights the 1803 advocacy of Reil of the University of Halle in Germany. Reil argued that “each asylum should have its own theatre with the roles in the plays distributed according to individual therapeutic needs”. (Italics in the original). Whitely (idem) further notes that Reil had seen work as “an essential aspect of therapeutic progressing from the requirements to maintain physical health, through artistic creativity, to mental activity.”

Whitheley (idem) describes the method of Planned Environment Therapy that was initiated in 1930s by Marjorie Franklin, a psychologist working with children. This method was based on “identifying the remaining healthy aspects of the personality in the subjects studied and utilizing such in an attempt to restructure the individual’s attitudes and function within a social and community environment.”

Notwithstanding the above described antecedent experiences, sociotherapy, is indeed widely believed to have its roots in the experimental works of various “psychoanalysts, psychiatrists and social psychologists in England around 1939-1945 and immediately afterwards” (Kennard 2004: 304). Two main experiments are regarded as the origin of sociotherapy. First, there was the experiment of Northfield, in which an old Victorian asylum was taken over for military psychiatric causalities (Whitely 2004: 237). Whitely (idem) argues that the innovation of Northfield was the initiation of group discussions and that the “task of the group was to study its own internal tensions…” (Italics in the original). Second, was the experiment of Mill Hill Hospital where the patients were also soldiers. The main force behind the Mill Hill experiment was Maxwell Jones who was in charge of the Effort Syndrome Unit.
There Jones saw what he gave to his soldier-patients as lectures developing into group discussions. "And from this experience he developed his ideas for the future task of the psychiatric hospital as a Therapeutic Community and the place within such for a community meeting." (Whitely 2004: 239).

In summary, Whitely (2004: 241) argues that "what emerged from these two innovative experiences...was very similar in terms of the concentration on the functioning and well-being of the hospital community, with less emphasis on the individual as the primary therapeutic target."

1.4.2. Sociotherapy: A revolutionary form of treatment

The therapeutic community approach is presented as a radical breakaway method from the "conventional" method of dealing with mentally ill people (Rapoport 1960, Edelson 1970, Bloom & Norton 2004, Kennard 2004). Not only the centrality of the milieu is emphasized in this approach but also the contribution of the patients/clients in their own therapy process.

In highlighting the situation of mentally ill people in a conventional hospital Rapoport (1960: 270) writes that "patients in conventional mental hospitals were seen (by people who initiated therapeutic community) as becoming ‘institutionalized’ through adaptation to the special conditions of a closed, impersonal, controlled, and bureaucratic social system.- patients were handled in custodial hospitals in an impersonal, standardized way."

Rapoport (idem) also describes the consequences of such an "inhuman" way of handling mentally ill people as affecting their personal needs and the future of their life in society. He observes that such "prison-like" ways of handling patients "tended to reduce their participation in, and ultimately their capacity for, forming ordinary social relationships; and it encouraged a passive, dependent relationship to the hospital authorities."

The therapeutic milieu was developed in reaction to the conditions described above Rapoport (idem) argues that "Rehabilitation ideals were initiated to counteract the effects of a prison-like environment.... ‘rehabilitation through reality confrontation’ is intended to make the hospital as much like the ordinary world as possible, and the adjustment of patients to this microcosm is assumed to prepare them to adjust to society outside."

Like Rapoport (1960), Bloom & Norton (2004) describe the emergence of sociotherapy in the area of helping mentally ill people as a revolution in relation to what was happening earlier,
they argue that a “..therapeutic community is in many ways a subversive idea in that the goal of the Therapeutic community is not to maintain a happy status quo but to create the “heat” that generates change. This change is generated largely through the democratically informed interactions between staff and clients and with each other” (Bloom & Norton 2004: 230). Moreover Bloom & Norton (2004: 231) emphasize the idea of the emergence of the therapeutic community as subversive by describing the status quo as “militaristic, hierarchcal, and frequently punitive and retributive…”

Kennard (2004: 299) also describes the emergence of the therapeutic community as a drastic shift in managing mentally ill people. According to him “[it] was quite revolutionary at the time, and the Retreat also gave priority to the value of personal relationships as a healing influence, to the importance of useful occupation, and to the quality of physical environment.”

Kennard (idem) also notes that the “revolution” was about altering the system as much as it was about changing, staff-patient relationships for the better. He remarks that “in its early days the therapeutic community approach was very much about changing organizations...staff who for decades had managed patients with a mixture of control and protectiveness, and sometimes abuse, and who had run the institution in ways that suited their own convenience, were suddenly asked to give patient responsibility, to consider the social and personal needs of patients.”

Following the success of the Northfield and Mill Hill experiments and numerous visits by psychiatrists from other countries, the method used in United Kingdom spread to other countries and were adopted by their mental health systems. Kennard (2004: 305) remarks that in 1981 he noted that 11 out 15 European Union member countries had already developed the therapeutic communities. In the Netherlands, he added, the method developed from 1970s and “formed a major part of the main stream psychiatric provision.” For many years now, sociotherapy is one of many available of treatments offered to traumatized refugees in different clinics in the Netherlands. It is important to note that sociotherapy as it is known and practiced to day in the Netherlands is a later development of the movement of therapeutic community that emerged in England during the Second World War.

According to the Foundation Centrum’ 45 in the Netherlands there are three theoretical concepts that are important in sociotherapy based on the “professional profile of sociotherapits of the society for Furtherance of Sociotherapy”; socialization, social systems
and social identity. Socialization "means that learning to deal with yourself and others takes place by sharing or learning to share information about yourself with others." (Foundation Centrum'45-2008).

Regarding social identity, they argue that a person has many social identities; a social identity that "is based on the behavior, positions and roles that are dictated by different social situations, social structures and actual interactions." (Foundation Centrum'45 2008). For this group the main focus of sociotherapy is on developing social identity they believe that sociotherapy works within a given social system. They point out that "the clinic can be seen as a social system to which people are admitted for a short or longer period of time, in order to learn how to deal with themselves and others and to reduce their disturbing behavior. Sociotherapists create an environment in the clinical system so that the clients admitted to the system can function to the optimal extent." (Foundation Centrum’ 2008 a).

It is worthwhile to mention that the above described concepts all emphasize the element of human interactions with people and the environment. This study assumes that before moving to the Netherlands, refugees have had their social and personal lives affected by their experiences with political violence in their countries of origin. In this regard sociotherapy is expected to help refugees regain some sort of normality’s in their lives.

According to the Foundation Centrum’ 45 (2008a), the professional profile of sociotherapists “living together, working together and solving various problems together in the present-day situation can contribute to the treatment. In this way one can for instance learn to trust others again or to stand up for oneself. By living day in and day out in a group, people learn with and from each other. This method of learning- is led and guided by sociotherapy.”

In the light of Rwandan experience with sociotherapy and the experiences highlighted in the literature, it appears that there is difference between sociotherapy in Rwanda and sociotherapy in the Netherlands in terms of agendas and power relations between clients and sociotherapists. On the one hand, sociotherapy in Rwanda cannot be labeled revolutionary because it has been contextualized and has taken on many Rwandan traditional and cultural elements, like singing, dancing and praying etc. In Rwanda, the milieu in which sociotherapy is done is actually ordinary and it doesn’t have to be “made” ordinary in the way Rapoport (idem) suggests to make hospital an ordinary world.
Indeed it is the flexibility in choosing the variety of milieus that emphasizes the ordinariness of the method as a whole and the milieu in particular. On the other hand, sociotherapy in the Netherlands is done in the two clinics, underlining the illness of the clients as well as the power relations between patients and health staff.

The question is, how does the hospital milieu influence power relations between sociotherapists and clients? Rapoport (idem) speaks of the “adjustment of patients”; in this case refugees from various countries who are in psychiatric clinics; what does “adjustment” mean in terms of relationships between refugees and health staffs? What influence does it have on the meaning refugees give to trust?

In Rwanda sociotherapy is done by ordinary people in an ordinary milieu with a view of helping beneficiaries live an ordinary life, while in the Netherlands sociotherapy with refugees is meant to facilitate their assimilation into a new social system and norms. Refugees come from countries with socio-centric worldviews and have to adapt to a more individual oriented world view, which means that sociotherapy has to empower them to act as individuals not as members of a group.

1.4.3. Who are Refugees?

For many years the phenomenon of refugees and asylum seekers has been a subject of study. Some studies have focused on “who” are the refugees and the reasons of their refugeehood. Others have focused on the challenges of refugees once they are out of their communities, such as suffering from trauma following violence in their home countries and the difficulties of integrating their new “home” countries.

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3 In this study, socio-centric is understood as “socially oriented” (http://dictionary.reference.com/browse/sociocentric August 09 2008). This concept is relevant in understanding the social context in which sociotherapy is done in Rwanda. It is equally important in understanding non-western societies from which refugees come and the possible difficulties they are likely to face once they are here, in the Netherlands. Rwanda is a socio-centric society in the sense that people depend on each other for sharing goods like water, salt, food, iron box etc. They also give each other moral support by being present in such events as funerals, weddings, births -- such practices and attitudes make life in Rwanda more communal than individual
According to the UN Convention Relating to the Status of Refugees (UNHCR, 1951), a refugee is defined as any one who,

“owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, or membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or, owing to such fear, is unwilling to avail himself of the protection of the country” (quoted by Miller and Rasco 2004: 5).

However Shacknove (1985: 275) highlights the controversy surrounding the definition of a refugee. He argues that “a conception of ‘refugee’ is not, strictly speaking, a definition. There are in fact dozens of definitions in effect within various jurisdictions.” In the light of diverse definitions for refugees, Shacknove (idem) describes four points that form the basis of the definitions, “a) a bond of trust, loyalty, protection, and assistance between the citizen and the state constitutes the normal basis of society, b) in the case of refugee, this bond has been severed; c) persecution and alienage are always the physical manifestations of this severed bond; and d) these manifestations are necessary and sufficient conditions for determining refugeehood.”

The above mentioned points indicate that indeed prior moving to their new “homes” people have their interactions with people and society disrupted, which can result in not trusting other people and the society in general. The situation of refugees in the Netherlands appears to meet the above described conditions as many refugees and asylum seekers have serious psychological problems as a result of trauma’s caused by persecution, war or violence. (Foundation Centrum’ 45 b).

Along the same lines, Miller and Rasco (2004: 16) argue that “living through the horrors of war and other forms of political violence clearly takes its toll on people’s psychological well-being”. The conditions of refugees call not only for rehabilitation but also integration into their new society. As Miller and Rasco (idem) put it “…painful post-traumatic stress reactions do appear to be highly prevalent within refugees communities, and for a significant number of these trauma survivors, time alone does not appear to lessen their distress.” Cultural differences are a challenge when helping refugees with mental health problems, and Miller and Rasco (2004) view cultural differences as having implications for mental health interventions.

According Miller and Rasco (2004:31) western models of treatments are perceived by many refugees “as culturally alien and in some cases highly stigmatized.”
In this regard Miller (1999:283) argues that although psychotherapy and other conventional clinic-based treatments play an important role in dealing with mental health of refugees, used alone they are inadequate, therefore he succinctly suggests "the need to complement such services with a variety of culturally grounded, community-based strategies that do not require attendance in formal mental health settings." The question I will address below is: in what ways does sociotherapy fit in this vision?

Writing on the experiences of refugees in Switzerland, Gross (2004: 163) highlights the problem of trust between refugees suffering from trauma and the medical staffs that treat them, Gross argues that trust between doctors and patients is "challenged when doctors and patients interact on the basis of mistrust, as often happens, given the larger political, economic, and social framework of their interaction." In light of the Swiss experience, this study seeks to explore the basis of interaction between refugees and sociotherapists and the role of trust in these relationships in particular.

1.4.4. Trust

"Over the years scholars have studied trust from several disciplinary perspectives" (Bhattacharya et al.1998: 459). And as a result the concept of trust has been widely defined and interpreted, yet "no clear definition of trust exists" (Bhattacharya et al. Idem). Although to date there is no universally accepted scholarly definition of trust (Roussean et al. 1998: 394), scholars across disciplines have suggested a variety of definitions. For the sake of this research I will mention a few of them:

"Trust is a psychological state comprising the intention to accept vulnerability based upon positive expectations of the intentions or behavior of another" (Rousseau et al. 1998: 395).

Trust is "the willingness of a party to be vulnerable to the actions of another party based on the expectations that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party" (Mayer et al. 1995: 712).

Trust is understood "in terms of confident positive expectations regarding another’s conduct" (Lewicki et al. 1998: 439).

The above quoted definitions emphasize the relationship between the elements of expectation and conduct in defining trust. In this study this relationship is relevant since the
interdependence of these two elements is crucial to understand the relationship that develops between refugees and sociotherapists and the trust that relationship generates in sociotherapy.

1.4.5. Trust and human relationships

Many scholars have emphasized the centrality of trust in human interactions (Solomon and Flores 1998, Williams 2001, Lewicki et al. 1998, Lewicki et al. 2006, Miller 2004). Trust is also perceived as the yardstick of the dynamism in human interactions as Solomon and Flores (1998: 219) suggest, “Trust is part of the dynamics of a relationship (or a culture), even when it seems to be not dynamic or ‘in play’ at all”. In other words trust is “relational” (Solomon and Flores 1998: 206).

Although there is no single universally accepted perspective on trust, there are some elements that can be qualified as commonalities across all the approaches (Maguire et al. 2001: 286). These common elements not only cement an implicit “common” understanding of the concept of trust but also emphasize the fundamentality of trust in creating and maintaining human interactions. Among them are “prediction” (Maguire et al. 2001, Möllering 2001), “willingness” (Maguire et al. 2001, Lewiciki et al. 1998, Williams 2001, Mayer et al. 1995), “expectation” (Möllering 2001, Williams 2001, Lewiciki et al. 1998, Hall 2002, Doney, Cannon and Mullen 1998, Rousseau et al. 1998) “vulnerability” (Doney, Cannon and Mullen 1998, Mark A. Hall et al. 2001, Clark 2002, Rousseau et al. 1998), and “faith” (Möllering 2001, Lewis and Weigert 1985). All in all, scholars from across many disciplines agree that trust is the key element to human relationships. As Lewis and Weigert succinctly put it “trust in general is indispensable in social relationships” (Lewis and Weigert 1985: 968).

In the Rwandan context both sociotherapists and beneficiaries understand trust in relationships in terms of activities and services that people share and exchange in their communities. Such activities and services include lending salt, a machete, an axe, or a hoe from a neighbor, or leaving one’s child with a neighbor while going to market or to hospital, or working together on the same field, a home visit for the sick or the bereaved family or for a new born baby, exchange of greetings and conversation.

For them trust is not static as some scholars have treated it (Rousseau et al. 1998: 395), but rather it is dynamic and an indication of the viability of relationships, as Rousseau et al.
(idem) argue "trust changes over time—developing, building, declining, and even resurfacing in long-standing relationships." Indeed it is through the above mentioned activities and services that Rwandans develop or lose trust in their relationships.

It is important to note that the significance of exchanging services or greetings or sharing activities is determined by the realities of the Rwandan social context and how the Rwandan people interpret it.

Bisharat (1997: 664) notes that "'trust', while essential to human existence, is overwhelmed by mistrust, besieged by suspicion, and relentlessly undermined by caprice in the extraordinary experience of refugee." In this regard therefore, trust for refugees is not static but rather dynamic and shaped by their experiences. Bisharat (idem) further remarks that "the trust that is shattered when refugees are created by systematic violence and the mistrust that replaces it and stubbornly persists, even when the conditions that originally fostered the mistrust have abated...refugees both mistrust others, whether in home or host societies, and are often mistrusted by them."

Using the theoretical concepts of control, agency and power this study will attempt to understand the meaning refugees in the Netherlands engaged in sociotherapy give to trust based on their stories and interpretation of what trust is.

This study draws extra motivation from questions raised by Hupcey et al. (2001) as challengers for future researches;

- "Can factors that enable the development and maintenance of trust be identified and transferred?"

- "Is there a difference between immediate trust of a class of individuals (such as patients toward physicians) and trust built over time with a particular individual?"

- "What are the differences between the loss of trust and never having trust (mistrust or distrust)?"

- "How is trust re-established once it is lost?" (Hupcey et al. 2001: 290).
1.5. Methodology

1.5.1. Study location

This study was conducted in two clinics where sociotherapy is one of services offered to traumatized refugees here in the Netherlands. The first clinic is De Vonk-Noordwijkerhout, which has treated traumatized refugees since 1994.

The second center is Equator Foundation operating within the Amsterdam Medical Center (AMC). Since 2003 the Equator Foundation received traumatized refugees and has offered them sociotherapy.

1.5.2. Study design

This is an explorative, descriptive, as well as comparative study on sociotherapy and trust in the Netherlands and considering my experience with sociotherapy in Rwanda. This is an entirely qualitative study and used assorted methods of data collection.

1.5.3. Data collection techniques and sampling

1.5.3.1. Participant observation

I evenly divided the time I had for my field work between the two centers. I spent three weeks at the Equator Foundation in the AMC and three weeks at de Vonk- Noordwijkerhout. I used observation as one of my main techniques of data collection. The purpose of participant observation was to monitor what goes on in a clinic for traumatized refugees with a particular focus on sociotherapy. I gave special attention to both personal conversations and group discussions. I joined clients (refugees) in other activities that they conduct in the clinics, such as sharing food and drinks as well as other therapies such as sports and creative therapy.

As participant I was able to have a first hand experience in sociotherapy in the two clinics in terms of the refugees interactions with sociotherapists, among themselves as well as interactions with other people in the clinics.
1.5.3.2. Interviews

1.5.3.2.1. Key informant interviews

In each center I interviewed two sociotherapists (one man and one woman), to get their insights on their practical experience in sociotherapy. They explained to me in detail what sociotherapy is, and what is expected from the process. They also explained the role of trust in sociotherapy and in particular what it means vis-à-vis clients-staffs relationships, mental health problems of refugees as well as the life situations of refugees here in the Netherlands.

I also interviewed a medical doctor (psychiatrist) in each center to gain insight into the importance of sociotherapy in relation to the mental health problems of refugees. It was also important to get their views on the role of trust not only in sociotherapy but also in the whole process of treating traumatized refugees. In total I interviewed 6 key informants.

1.5.3.2.2. Interviews with refugees

The main objective of this study was to explore what trust means to refugees who are participating in sociotherapy so it was important to talk to refugees in both clinics. Interviews with refugees allowed me to have insight into what sociotherapy is and does for one’s understanding of trust, from a beneficiary’s perspective. Interviews with refugees allowed me to have insight into their life histories both in their country of origin as well as here in the Netherlands. This information was crucial to understand the importance of sociotherapy in relation to their traumatic experience as well as the meaning they give to trust. In total I interviewed 6 refugees.

1.5.4. Data analysis

Interviews were conducted in English, except one in Dutch and another in Persian. On each occasion I had a translator fluent in English and Dutch or Persian. With one exception all interviews were digitally recorded; the contents were transcribed and written down for analysis. The notes taken during or after participant observation were compiled and written down for analysis. The data was analyzed according to the themes that arose in the data collected during the field work and projected into chapters in relation to the objectives of this research.
1.5.5. Ethical considerations

This study endeavored to respect the requirements of ethical standards. I followed the agreement I had with the two clinics and rules they deemed I had to know and respect in the course of my field work in these clinics. However refugees are delicate people to talk to because of their recent violent past and in most of cases uncertain future. Therefore, most of my respondents preferred to remain anonymous and I respected their wishes. Moreover, talking to refugees about their lives can be highly emotional; therefore it was crucial to express sympathy, patience and understanding when speaking to them.

1.5.6. Study limitation

My main challenge in this study was the language barrier. Both clinics are conducted in the Dutch language, especially because in sociotherapy one of the goals is to help the clients (refugees) learn more Dutch. Nevertheless, I was always invited to participate in all meetings and group discussions related to sociotherapy. I had to rely on briefings from whoever was sitting besides me. Unfortunately in most of cases that was not enough to get all the details that might have been crucial to this study. The other obstacle was my own position and identity in sociotherapy and this was more of a problem with the clients.

Although they had been informed about my status before I was introduced to them on the first day, they still found my presence dubious and confusing. After a few days some clients could even ask me whether I was also a patient or a refugee like them. This could explain why some of the refugees agreed to talk to me but eventually did not turn up for the interview. Others did turn up but seemed so scared and suspicious about giving any useful information. My field work period at De Vonk Noordwijkerhout coincided with a bus strike in Leiden, which meant that I had to rely on someone to come from the clinic take me from the Voorhout train station, consequently sometimes I missed early morning sessions of sociotherapy.
1.6. Conclusion

Using examples drawn from the Rwandan experience of sociotherapy, this chapter highlighted the perspectives through which the meaning of the trust for refugees going through sociotherapy can be analyzed. Moreover, this chapter surveyed literature on the origins and development of sociotherapy, refugeehood, and trust. The reviewed literature in this chapter highlighted some ways in which the Rwandan experience of sociotherapy is different and raised questions that will be answered in the following chapters. The next chapter analyses the reception of refugees upon their arrival in the Netherlands with emphasis on historical, social, economic, and political factors.
2.1. Introduction

This chapter examines the socio-political contexts in which refugees find themselves once they cross borders and come to the Netherlands in search of a safe home. The subject of Dutch policy towards refugees and asylum seekers and its metamorphosis over the last few years has been widely studied. Particularly in recent years as The Netherlands turned away from its internationally well known liberal and tolerant attitude (Cieslik and Jura 2002:135) to one of the strictest and less hospitable societies for refugees in the Western world.

Using some historical facts, findings and impressions from previous studies, this chapter attempts to highlight some factors that have been fuelling the current general hostile attitude towards refugees and asylum seekers in the Netherlands and the subsequent implications they could have on the meaning refugees give to trust. Refugees are received in an atmosphere of indifference and skepticism compelling them to be mistrustful and more concerned about their health and future. This chapter provides an over-view of immigration in the Netherlands over the years and highlights the consequences of the current Dutch immigration policies on mental health of the would-be refugees. Lastly, this chapter gives a description of some of the facilities and programs that are set up here in the Netherlands to respond to mental health related problems of the refugees, with a particular emphasis on sociotherapy.

2.2. The Netherlands: Full house, wary hosts

Immigration is not by any means a new phenomenon in the Netherlands, “the ‘Low Lands by the sea’ formerly had a great attraction to immigrants, particularly during the 17th century. During this ‘golden century’ the Republic, of which the present-day Netherlands was then a part, was the most flourishing country in Europe” (De Ruuk 2002: 2). De Ruuk (idem) also identifies the moments and events that compelled immigrants to move in great numbers to the Netherlands whether from neighboring European countries or from other continents.
She first mentions the First World War, during which “the country took in temporarily around one million refugees from Belgium”. The persecution of Jews in Germany and Austria in the 1930s that led tens of thousands of refugees into the Netherlands. There was also the shortage of laborers in the post-war period and the post-colonial period that compelled the Netherlands to conduct a massive recruitment of the so called ‘guest labourers’ from Mediterranean countries: Italy, Spain, Portugal, Yugoslavia, Greece, Turkey, Morocco and Tunisia. The laborers from Morocco and Turkey stayed on in the Netherlands while the others went back to their home countries.

The end of Dutch colonization also meant that the Netherlands took in thousands of people from former Dutch colonies. Thus when the Netherlands handed over Dutch East Indies to Indonesia in 1949, 273,000 repatriates and other migrants came to Holland. When Surinam became independent in 1975 the consequence was the migration of one third of the Surinamese people to the Netherlands. All these migrants were later joined by their family members and by 2002 the Netherlands counted 315, 117 Surinamese people. (De Ruuk 2002: 3)

The flow of people moving to the Netherlands continued over the years and took a new dimension from 1970s onwards. The Netherlands started to receive more and more refugees, “The late 1980s-early 1990s saw an increasing number of refugees arriving every year” (De Ruuk 2002: 3). But in the late 1990s and early 2000, the number of those seeking asylum in the Netherlands started to decrease, as immigration became a hot and problematic topic in the Netherlands, pushing politicians to make much stricter asylum policies.

In recent years, “the Netherlands has left behind its traditionally protective stance toward asylum seekers to take up a restrictive approach that stands out among western European countries” (Van Stokrom 2003: 1). The realization that the Netherlands has become stringent in accommodating more refugees for it is saturated with them has moved beyond the political arena and caught the public attention, “now notions such as ‘full is full’ (the country is full) have become commonplace” (Van Stokrom 2003: 2).
Few would argue that such utterances are not based on the fact that the Netherlands is one of the smallest countries in the world,ironically one of the most densely populated, it is ranked twenty-third in the world with a population of 16,491,461 on an area of 41,526 Km$^2$. (Wikipedia 2008).

Moreover skepticism and hostile feelings about the whole idea of refugeehood by the general public has overshadowed the tolerance and the kind-heartedness the Dutch society had always been known for. As Van Stokrom (2003: 1) puts it, "immigration policies have become very strict and the attitude towards foreigners generally hostile. Racist tendencies are emerging as a fear of foreigners is exploited in order to create a sense of Dutch national identity."

Realizing that the general feeling in the Dutch society against foreigners and Muslims, in particular, has hardened, politicians keenly stoke this feeling, afraid that being perceived as soft on the issue will lose them votes (Van Stokrom 2003: 3). This tendency is palpable in the fact that the government is thinking of new ways of making the regime even tougher, especially for ‘official’ asylum seekers (Van Stokrom 2003: 4).

In relation to the strictness of asylum policies in the Netherlands some studies have shown serious concerns about the rights of refugees who seek asylum in the Netherlands; in this regard for example Van Stokrom (2003: 2) highlights the concerns of The Triumph of Efficiency Over Protection In Dutch Asylum Policy (Italics in the original) that appeared in its reports. He writes, "it identified three main areas in which the Dutch state violated international human rights legislation: ‘inappropriate treatment of migrant children’, ‘restrictions on asylum seekers’ rights to basic material support, such as food and housing’ and the 48-hour policy, the so-called AC (Aanmeldcentrum)-procedure."

Human Rights Watch (HRW) also has concerns especially with regards especially to AC procedure whose end results may put the lives of the would-be refugees in danger if their request to secure a safe place in the Netherlands is turned down. In this respect, HRW notes that "The AC procedure is regularly used to process and reject some sixty per cent of asylum applications, including those lodged by people fleeing countries torn by war, ethnic strife, and grave human rights abuse.” Above all, independent judicial review of this process is not taken seriously.” (Van Stokrom 2003: 2). In the same vein of thoughts, some authors have voiced
their concerns about the toll the new stricter asylum seeking procedures can have on the health and overall well being of refugees. Basing their arguments on the experiences of refugees they talked to, Cieslik and Jura (2002: 135) showed how the eight-step process of asylum application not only dehumanizes refugees, but also contributes to the destruction of personalities of refugees who go through it.

Refugees are put through many long and difficult interviews characterized by skepticism and indifference to the sufferings of the refugees. In this regard, Cieslik and Jura (2002: 136) argue that “It must be humiliating for refugees to think of more sophisticated narratives, to feel their own traumatic experiences inadequate and unimportant, to have to persuade this white collar Dutch worker that their life deserves to be saved.”

The indifferent reception refugees get when they arrive in the Netherlands is not only motivated by the lack of room for more people or the current hostile policies and public feelings, but it is also motivated by the fact that not every one who claims to be a refugee is genuinely a refugee. This means that the system of handling refugees affairs in the Netherlands as Cieslik and Jura (2002: 137) note, “is made to deal with refugees efficiently, impersonally and bureaucratically.” In order to screen out liars, interviews with refugees are conducted skeptically. In the end that way of dealing with possible misuse of the opportunity by people coming in has a negative effect on genuine refugees. The current immigration policies have significant implications for asylum seekers as their personal story is diminished. Their privacy is removed. (Cielslik and Jura 2002: 137).

Many authors including Cieslik and Jura (2002), Weinstein and Stover (2002) argue that the asylum seeking system, which in most of cases is marred by long periods of waiting as many applicants have to appeal against negative decisions, has negative effects on the mental health of refugees. For instance when the asylee’s application is turned down, the subsequent appeal process may take a long time, causing much uncertainty and stress that can affect adversely the asylee’s psychological state (Weinstein and Stover 2002:307). In the same vein of thoughts, “This anxiety is magnified by the endless amounts of free time the refugee has. This vacuum of waiting and worrying can consume their lives.” (Cielslik and Jura 2002:137).
With the current immigration policies in the Netherlands, refugees have to go through a long, difficult and traumatizing process before a few lucky ones are allowed to stay and start a new life in their new home country, as Ceislik and Jura (2002: 136) put it “...the processes create the passive, traumatized personalities of many refugees.”

Nevertheless notwithstanding the much talked about and criticized policies of inhumanly treating refugees and asylum seekers as they seek to settle in the country, the Netherlands, as Weinstein and Stover (2002:307) observe “ wants to restrict admission of refugees into the country while remaining hospitable to the “real refugees”-the so-called firm but fair policy.” In this regard, facilities and programs were put in place to take care of the health as well as the general well being of refugees. This study has focused on two centers that offer mental health services to traumatized refugees, with a particular emphasis on sociotherapy as one of the services. The following is the introduction of the two clinics where the study took place.

2.3. Equator Foundation

The Equator clinic, initiated by psychiatrist, Dr. Pim Scholte operates within the Amsterdam Medical Center (AMC). Scholte was a member of Médecin Sans Frontières (MSF) in the Netherlands and was inspired to open a clinic while he was working with MSF from 1989-2002. As soon as he entered the organization he realized that nothing had been done about the mental health of the staff as well as the target population they work for. He argues that the MSF staffs who go to conflict zones come back shocked and there is nothing to prepare them for anything that may affect them mentally before they leave.

Therefore, he assisted the MSF in developing a mental health program for the staff as well as for the people they work for. Meanwhile he was working in the hospital with young schizophrenic patients, when time came to concentrate all his time on his hospital work, he was given the opportunity to focus on refugees and asylum seekers owing to his expertise in working in cross-cultural settings and post-conflict contexts.
In his view, in order to work with refugees and asylum seekers a day clinic was needed because, he argues that,

“meeting a person for one hour, every two weeks will not make much difference because they have been living here in Holland and they live in very stressful situations. Although they have left their home countries to be safe and secure, when they arrived here it has not been very much better. I think that to be able to contribute to making them feel better, you need more intensive treatment and you can contribute to that through day care” (Pim Scholte, oral interview, June 2008, Amsterdam).

In order to materialize his idea Scholte needed to find someone “powerful”, a sociotherapist, to start the program with, because he wanted to focus not so much on medical symptoms, for as he puts it,

“I have been always convinced that medical work usually doesn’t take into account sufficiently the surroundings and the context people live in. From the medical perspective, there is not much attention for people’s social context. This is not completely correct because you cannot work with people and isolate them from the situation and the context they come from. I thought, in our approach we should also take into account the context people had been living in and the context they are living in at the moment, and that we should provide them with a new and safe context, at least as part of the treatment, hence the idea was that there should be something like sociotherapy (Pim Scholte, oral interview June 2008, Amsterdam).

When his proposal got accepted by the European Refugee Fund and he received the grant, Scholte started his clinic in August 2003 with a professional nurse who was also a sociotherapist. They started with four clients but soon realized that the clinic could receive 8, or 10 even 12 clients. It was agreed upon with the nurse at the beginning of the program that political debates or discussing issues that are in the news whether in the Netherlands or other European countries should be part of sociotherapy, instead of focusing only on sickness or health situation of the clients. In this respect, Scholte argues that,

“many people think that if you are a medical doctor, you should not take position in politics and my conviction is that you cannot separate the two. Because you live in a certain context, which is not only influenced by politics but also by economics and you are part of it. You cannot isolate human beings from their surroundings” (Pim Scholte, oral interview June 2008, Amsterdam).

He thought that it should be part of sociotherapy and that it should be acknowledged that people are part of the system.

Scholte said that the main objective of sociotherapy is not so focused on trauma. Sociotherapy is not a therapy to treat trauma-related psychiatric symptoms, it is about addressing other issues that are at stake when people are traumatized and are not translated into the language diagnostic terms or symptoms. These are things like the sense of meaning of life, the feeling of being connected.
Bearing in mind that these are people (refugees) who have lost their sense of meaning of life, people who are alienated from others, they don’t have any trust in others and they don’t see any perspective, therefore the main objective of sociotherapy is to restore that side of traumatized people which has not been easily translated into the language of symptoms.

Scholte believes that sociotherapy helps refugees in two main ways. One, sociotherapy offers the opportunity to be acknowledged as human beings, be treated respectfully, being left alone in the sense that one doesn’t have to fill any criteria when she/he joins the sociotherapy group at Equator. In Equator clinic everyone’s views are solicited, discussed and respected. In his view sociotherapy is a new experience for people who have been oppressed or have been humiliated or have not been treated with dignity.

The second way in which sociotherapy helps refugees is that it helps them to interact not only with fellow refugees but also with other people. They start to notice, “that still there are people who are worth trusting, and they start to like people. So if you accept to be trusted or trust the other sometimes you get used to each other, and then it is nice. Every time you go back to the clinic there is a group of people that you trust, which is a new experience” (Pim Scholte, oral interview June 2008, Amsterdam).

Clients are referred to the Equator clinic by other psychiatrists or mental health institutions who are aware of Equator’s services. Clients visit the clinic three days a week, from 10 to 4 o’clock for a period of few months, and they spend their time in a group of about ten people.

Below, is a table of an overview of the clients who have received day clinic services at the Equator from 2003-2008.
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2.4. De Vonk-Noordwijkerhout

The clinic of De Vonk-Noordwijkerhout is one of the four treatment units of Foundation Centrum’45. The Foundation was established in 1973. It is the national centre for medical-psychological treatment for members of the resistance and victims of war and organized violence. In order to realize its aims, Centrum’45 offers a broad range of therapies (Foundation Centrum’ 45 2008).

Since 1994 De Vonk-Noordwijkerhout has been offering treatment to traumatized refugees. It includes a clinic for 24 clients, a day clinic for 8 clients and a polyclinic (Foundation Centrum’ 45 2008). Clients who are treated at De Vonk are refugees and asylum seekers who have experienced different forms of political violence in their home countries and often have been compelled to leave their country because of persecution, incarceration, sexual violence and torture, possibly in combination with war. Many have found themselves in life-threatening situations or have seen members of their immediate family threatened. Their living environment may have been suddenly destroyed. Their siblings have been killed or are missing. They were often forced to go into hiding or stay in a refugee camp before they finally made it to the Netherlands. (Foundation Centrum’45 2008). With time, among the problems that these traumatized refugees develop are depression, panic attacks, phobias, insomnia, nightmares, intrusive images of war and strong feelings of distrust and feeling unsafe (Foundation Centrum’45 2008).

Among other services offered to the clients at De Vonk clinic is sociotherapy which in fact plays the role of coordinating other therapies as is clearly stated as the core of treatment formed through a community under the guidance of sociotherapists-nursing staff. (Foundation Centrum’ 45 2008). Furthermore, sociotherapists, lead the clients to give form to their every day life. The daily and continually open method of exchanging information (communication and interaction) is the major concern of sociotherapists. The daily life, and interactions with each other, provide the sociotherapist with information about the potential and limitations of the clients and the sociotherapist adjusts his/her interventions according to this information. (Foundation Centrum 45’ 2008).
In an interview with one of the most experienced sociotherapists at De Vonk I was told that sociotherapy teaches people (refugees) how to deal with their individual problems together with other people, in a group. On the one hand, there are individual problems because people are traumatized and in this case, all are traumatized refugees. On the other hand, most also have to face social problems related to communication, which means that they have to learn how to communicate better, how to trust other people. Therefore, sociotherapy provides an environment where people are together with similar problems and one can learn from all kinds of situations how to deal with problems in a way that is different from the way one was used to. People go through sociotherapy because in most of cases they don’t know how to relate to partners, neighbors and most are isolated therefore in sociotherapy the sociotherapists help the refugees to socialize. The sociotherapist also told me that he does not only focus on social aspects but also he observes for psychosis, depression, about PTSS, and personality problems because all of these things are interconnected.

Most clients are sent to De Vonk by the Medische Opvang Asielzoekers Foundation (MOA) medical people working in the Asiel Zeezers Centrum (AZC), which are accommodations for asylum seekers who wait for their decision to stay in the Netherlands or be sent back home. Out of the 24 clients who were at De Vonk during this study, 12 are living in AZC, 4 have their own housing and there are 8 children who have come with their parents. The sociotherapist told me other clients come from clinics who deem that De Vonk is a better option for traumatized refugees than going to a general psychiatric clinic. De Vonk clinic only admits clients who have refugee status or those who have a justified reason for believing that they may remain in the Netherlands for a considerable period of time. (Foundation Centrum '45 2008). It is important to note that both clinics, Equator and De Vonk, have other forms of therapies and activities that aim to help clients with their mental health problems and, I will discuss some of them in the next chapter.
2.5. Conclusion

This chapter has analyzed the different aspects of the context in which refugees find themselves when they seek to secure a safe, new home in the Netherlands. Throughout the years the Netherlands has been known for being hospitable and tolerant towards refugees and other types of immigrants, but in the last several decades this well-known attitude have faded away as the Netherlands is now one of the countries with the strictest immigration policies in Europe and the world over.

In view of the fact that the Netherlands is one of most densely populated countries in the world, the possibility of misusing the system by economic immigrants and also an increasing hostile public feeling towards refugees in recent years, politicians have made laws that make it more difficult for refugees and asylum seekers to stay in the Netherlands. In this respect the processes of application for refugee status are taking longer and are always marred by skepticism and indifference to the suffering of those who genuinely deserve to be protected. Nevertheless throughout the country there are facilities and programs that are set up to help refugees who experience health problems, especially trauma related problems mainly because of their past experiences. This study has focused on two clinics and more specifically on one program, sociotherapy, which is designed to help refugees deal with trauma related problems. The next chapter will describe the day to day experiences of sociotherapy with refugees in the above-mentioned clinics with a view of understanding of what takes place in sociotherapy and how it influences what trust means to refugees.
CHAPTER THREE
EVERY DAY EXPERIENCE IN SOCIO THERAPY: REFUGEES LIVING AN ORDINARY LIFE IN AN EXTRAORDINAR Y HOME.

3.1. Introduction

The aim of this chapter is to give a detailed account of what I experienced, saw and heard in the sociotherapy groups, in both clinics of Equator and De Vonk-Noordwijkerhout. This chapter will show how clients live an ordinary life in an extraordinary setting. This chapter highlights the issue of power relations that is evidenced in the interactions of the sociotherapists and clients, it also shows how the clients use their agency in sociotherapy to influence the above mentioned interactions. This chapter has a comparative description of sociotherapy in both clinics in terms of group discussions, other therapies and cultural differences. To achieve the above-outline objective, this chapter will give a description of a one day sociotherapy experience in each clinic, a description of other therapies available and issues of cultural differences. Throughout this chapter comparisons are made between the Rwandan experience and what happens in the two clinics.

3.2. Observing a sociotherapy group: an activity and a technique of data collection.

As I indicated in the first chapter, spending hours in a sociotherapy group was not a new experience for me. Shortly after the launch of the implementation of a sociotherapy program in the Northern Province of Rwanda I had the opportunity to visit various sociotherapy groups, and I spent hours and even months with some of them.

Occasionally I was just a visitor passing by and enjoyed the warm welcome the groups extended to me and I deemed it worthwhile to spend a couple of hours with them. But on other occasions, my presence was just more than a routine visit, I was a researcher, looking for information, desperate to understand what was going on there, who says or does what, when, how and why? With such kind of questions in the back of my mind, my presence in the group was problematic, my motivation and interest were far different from those people I was sitting with. At times I felt uncomfortable, even frustrated when things went in the opposite
direction of what I wanted or hoped for. For instance a topic I deemed more interesting was overlooked, instead, another which I least expected to be discussed in group would come up from nowhere and take all the time we had for the day even for the following couple of days. I learned not to expect but to wait and go along with whatever came up.

In January 2008 when I finally chose the Netherlands over Rwanda as the country for my fieldwork I immediately initiated contact with potential centers that might allow me to do my fieldwork on their premises. Having already had some contacts with people at Equator my request was easily accepted but nothing was taken for granted at any moment. I made my first visit to the clinic at the end of January but it was no more than an exploratory visit to meet people who work there and share my research interest (sociotherapy and trust) with them. Everyone present promised to help me in any way he/she could, provided I gave them my schedule well ahead of time so that they could inform their clients about my participation. Two months later, I made my second visit after which I sent my schedule of days I was to be there, which of course corresponded with the days of sociotherapy, Monday, Wednesday and Friday. They also wanted to know what activities I intended to do in my field work. In my answer I mentioned that my main activities would be participant observation and interviews of both staff and patients. The fact that I was not to do or participate in any medical aspects, my request to do fieldwork in a medical setting was accepted without difficulties. Nevertheless, they had concern for me: “every thing is in Dutch here” they told me.

My request to do fieldwork at the De Vonk-Noordwijkerhout was channeled in a more or less similar way. After two visits, telephones calls, a letter from the University and a letter saying that I would only observe what goes on in sociotherapy and interview some clients and staff members, I was guaranteed the permission to do my fieldwork in the clinic. Once again the fact that I was not to interfere with their medical practices made it easier, but I was again warned beforehand that every thing was in Dutch. I had earlier negotiated with the two clinics that I would do my field work in one clinic first before moving to the other. The reason for this was that an attempt to do my field work in the two clinics simultaneously would make my presence intermittent which could disrupt or interfere with their organization. In the end it was in my best interest to focus on what one group did and the individual members at least during the time I was there.
When I started to observe sociotherapy groups in Rwanda, two problems emerged. One was that telling the beneficiaries my true interests could have been counterproductive. Rwanda is still a delicate context in many ways, especially in a group of ex-prisoners saying that you are there to observe everything they do and say could have interfered with the normal proceedings of the group. The second problem was that somehow I had to tell the sociotherapists who facilitated the group about my purpose and they thought that I was there to evaluate their performance as sociotherapists, which initially made them ask me why I had chosen them from all the possible sociotherapy groups.

We agreed that for the sake of the beneficiaries I would introduce myself as one of the sociotherapists. I had spent a great deal of time with the sociotherapists during their training acting as a translator and I was a native Kinyarwanda speaker so it was feasible for me to assume that role, although it interfered with my overriding motives. On numerous occasions I found myself facilitating group discussions instead of sitting back and taking note of what was happening. But there was no better option.

Since I had informed the two clinics in the Netherlands that observation would be one of my main activities this became my main technique for data collection. I was introduced as a student doing a fieldwork for his research, however at times after introducing myself as an anthropology student I found it difficult to explain what anthropology stands for to some clients, in fact I avoided mentioning “medical anthropology” for I thought that it could give me another an image in their eyes.

In both centers I was invited to participate in most of the clients’ activities, except of course individual meetings with doctors or psychiatrists. The fact that I don’t speak Dutch at all made my observation as a data collection technique all the more difficult because I could not follow exchanges that took place in staff meetings or sociotherapy group discussions.

In the face of this difficulty I opted to wait and capitalize on each opportunity, therefore when someone who speaks English whether a client or staff member had a minute I would raise one or two questions to clarify some issues. In this respect, I was inspired by the experience of Zaman when he was doing his ethnography in the hospital in Bangladesh. He noted that “collecting data is like catching a butterfly; if you run after it, it flees, but if you sit quietly, the butterfly sits right on your head” (Zaman 2004:34). I gradually learned how it is possible to gain information just by ‘hanging out’. The only difference between Zaman and
me is that I was not hesitant to raise suspicious questions; I was only waiting for the moment when it was possible to switch to English. Nevertheless I was and am still grateful to all who translated for me so that I could know what was going on in staff meetings or sociotherapy group discussions.

3.3. A whole day experience in a sociotherapy group.

3.3.1. Equator Clinic

The Equator clinic is located in the Psychiatric wing of the AMC building. A day of sociotherapy starts at nine in the morning with a brief meeting that lasts about half an hour. The meeting brings together psychiatrists, sociotherapists, social workers, and other therapists such as relaxation therapists or creative therapists. In that meeting the sociotherapist reads the report she/he wrote about the previous sociotherapy meeting, which is followed by comments and reactions. I was told that every six weeks, clients are discussed individually, following the reports the sociotherapists and other therapists would have done. They look at the main problems the clients have and discuss them with clients. They also ask the clients what they think is the main problem and what they think about it.

As in Rwanda, it is nearly impossible to pin down sociotherapy to one element. From the moment the clients arrive in the clinic in the morning until they depart in the afternoon, sociotherapy displays its different facets through interactions between sociotherapists and clients and between clients. Which means that sociotherapy is not about one predictable activity but rather a way of living at a certain moment and place and sociotherapy strives to help clients find their way through. On the other hand, clients are invited to own that process. In this regard, Edelson argues that “sociotherapy is concerned with the situation with which the person interacts, and which, in relation to his adaptive problem-solving, is the locus of means and conditions or constraints; the situation is also the source of goal-objects which he pursues, alone or in concert.” (1970:130). In the following section I will give a detailed account of what took place in sociotherapy one Friday in Equator clinic.

Officially the sociotherapy day starts at 10 AM in the Equator clinic with the arrival of the clients. If it is your first day and you have never met the clients before, then you cannot tell whether the person who has just come into the room is a client, an ordinary visitor or another staff member in the building. They come in one-by-one, most of them well-dressed, and at
first glance nothing is wrong with them and they seem to be very familiar with the place and the facilities in place. During my fieldwork Equator clinic had 9 clients, 3 women and six men. They come from Afghanistan, Iraq, Iran and Serbia.

Although it is in the hospital, the room where the clients come to in the morning is nothing but a normal large sitting room furnished with new comfortable orange couches, a coffee machine, always supplied with cookies and fruits and a radio. Therefore, every Monday, Wednesday and Friday when a client comes in, after removing his or her coat, he/she makes himself/herself a cup of coffee or tea, grabs a cookie, greets the sociotherapists and his/her colleagues if she/he is not the first to arrive and then joins in the conversation whether standing or sitting, and the day of sociotherapy has begun.

In the light of my Rwandan experience this was already a big difference. As in Rwanda the beginning of a day in sociotherapy is a more formal affair characterized by sitting in circle, a short prayer, followed by an announcement of the program. It may be argued that in Rwanda a sociotherapy session takes only three hours and is mostly dedicated to group discussions, while in Equator clients stay the whole day and in addition to sociotherapy they are invited to attend other therapies also.

On May 16, 2008, I attended the staff meeting and took the opportunity to request clarification about some of the issues I had noted on the previous day. The sociotherapist who read the report mentioned that one the clients requested him to write a letter for him in order to get a better house for the sake of his ill wife. Although the sociotherapist is not the one to do that, he told him how to go about it. I asked people in the meeting, why if these people have been in the Netherlands for over 10 years and speak Dutch do they still not know how to channel a request to find a house? One of the staff members answered me that, these people, the clients, actually don’t know how things work here in the Netherlands. They spend many years in AZC before moving out to the wider society. They don’t have a social network and lack confidence and have problems with communication. She noted that they bring sociotherapists all sorts of complaints like telephone bills, letters or other documents to read for them, and they always have financial problems because they don’t know how things work here and most of the time fall victims of crooks who take advantage of them.
One psychiatrist echoed her and told us how one client asked her to call the local authorities on his behalf over a garbage problem because he thinks that his Dutch is not good enough. “Dealing with the refugees” is like raising children, she added.

The general consensus among the staff was that if these clients have to feel better mentally, they also have to feel better physically. It is a challenge for the sociotherapists because sometimes they don’t know where to set limits. Nevertheless they said it is part of building trust between them and the clients.

The same morning I noted something that kept happening throughout my fieldwork at Equator. Each time clients from Afghanistan or even Iran had an opportunity to be close they would start to talk in their mother tongue then as soon as a sociotherapist would notice, he/she would immediately remind them that they had to speak in Dutch.

Approximately 11 o’clock we had a group session, and moved to the next room, sat in a circle and had open discussions. The topic was about greetings in different countries and what kind of information one can ask during the first meeting.

Most of the clients said that in their countries people take time to greet each other and talk, but about the information to give out on the first meeting, there were some differences. In Serbia for example one client remarked that greetings are okay, but information such as the amount of money one earns each month are more private matters that don’t go out easily. While people from Afghanistan said they take time to greet each other and can talk about anything. The clients also said that here in the Netherlands people work all the time, they don’t have time for one another and are always in a hurry, while in their country they are freer and can visit each other.

Clients also said that in their countries people could go to market or a shop and take something home and pay later, but not here because no one knows each other. One the of clients asked me to tell them about my culture, how we greet and what kind of information one can give out after exchanging greetings. They also wanted to know what kind of relations students and teachers have in my country. I told them that teachers are important and more so in the university, they are respected and students are there to listen. People from Afghanistan told me that it is the same in their country. Clients discussed how difficult it is to get a job here if you don’t have proper papers. Even a refugee status it is very difficult to get a job with the qualifications from home. One man from Iraq noted how a medical doctor he knows was
not able to get a job here because his qualifications were not accepted. The meeting lasted about one hour and it was time to prepare for lunch which is cooked by one of the sociotherapists and in most of case he/she is assisted by one or two clients.

As usual one of the sociotherapists served all of us, but this time because it was a lady, two clients teased her saying “Mama Amy, Mama Amy” each time she gave a plate with food to one of us. We took some time of silence after which every one said eet smakelijk, “enjoy your meal” and we started to eat. We left the table at the same time and cleaned the table together.

As we were having coffee I asked one of the sociotherapists why they have to cook for the refugees and the answer was that some of the clients go for days without having warm meals. She told me that the clients who were saying “Mama, Mama” when she was serving were trying to provoke her and one of them moved out of the country (Netherlands) for a long time and when he came back his house had been taken and that is the cause of his problems and that is why he is at Equator. She also noted that they spent many years in centers and live with a lot of uncertainty and that is why they don’t know how things work here, she also compared them to children.

The rest of the afternoon clients and sociotherapists played two games that were meant to help clients build on their Dutch vocabulary. I was invited to join. In one game each client would be given a paper with a name on it, like Amsterdam for example and then he/she would describe it in words and the group would guess what it is. The other game was to look at pictures on pieces of paper and then to choose the right proverb that describes the image. Both clients and sociotherapists seemed to have fun playing these games and the atmosphere was friendly and relaxed. After the game we wished each other a good weekend and the clients departed.

3.3.2. De Vonk clinic

My experience with sociotherapy in De Vonk clinic was different from what I experienced at Equator clinic in many ways. At De Vonk clients are housed in the clinic, from Sunday evening to Friday afternoon and those who have children come with them. Men have their rooms on one side of the building while women and children are on the other side. It is a much bigger group 24 clients compared to 9 clients in Equator clinic and they are from different countries: Liberia, Sera Leone, Somalia, Eritrea, Iran, Turkey, Afghanistan, Azerbaijan, Morocco, Cameroon, Armenia, Sudan, China, and Congo.
Because clients spend days and nights at the De Vonk clinic, sociotherapy is a twenty-four hour service unlike in Equator, but my field work could only be between 9:00 in the morning until 17:00 hours. At De Vonk each client has a mentor. He/she is contact person, a sociotherapist who knows the client well. He/she knows the client’s details, and meets the client regularly and the client also knows that he can go to him to arrange things or to talk about his treatment or have a conversation. A sociotherapist can be a mentor for one or more clients and the appointment of a mentor is a matter that is handled internally among the sociotherapists.

As in Equator clinic, during the day clients at De Vonk attended other therapies, both individually and in smaller groups. Because my interest was mainly in refugees and sociotherapy I paid particular attention to group or individual meetings where clients and sociotherapists had any form of interaction. At De Vonk sociotherapists work in eight-hour shifts and those who are on duty in the morning have an opening for day sessions with clients around 9 am. In the evening those who have taken over from the morning team have the closing of the day session with clients at around 5 pm. What was noticeable was that at De Vonk, not every client attends these group sessions. In the morning some clients are still in their rooms and in the evening some clients don’t join but are just around watching TV, or on the internet playing games or browsing various websites. This was a noticeable difference between the two centers, because at Equator sociotherapists always make sure that every one present attends the group sessions and they end the session together. At De Vonk clinic clients attend different therapies like music, creative or psychomotor therapies in smaller groups and sometimes simultaneously. In the following section I will give a detailed description of a whole day experience in sociotherapy at De Vonk on June 3 2008.

As at Equator, here too the day begins with a meeting when the staff members share the news about the clients but generally the sociotherapists inform other staff members about clients because they are the ones who spend the time with clients even when other staff has gone home the sociotherapists stay until late at night. Apart from sharing the news about clients they also update each other about appointments.

After the meeting, because I was particularly interested in sociotherapy, I went into the office of the sociotherapists to see how they work with clients who come in. In their office there is a mini pharmacy and clients come in the office especially in the morning and the
Sociotherapists give them medicine. Sociotherapists told me the medicines they give to clients are mainly painkillers and anti-depressives. Around 11 o’clock clients and staff have a coffee break and it was during this time that I met a male client. First he asked me whether I was “Theo” the student they had been informed about, then we started to talk about his life both in his country of origin and his new home country. He is fluent in Dutch, English and Arabic.

At De Vonk they have lunch at half past twelve, and sociotherapists take their lunch with clients, while other staff members such as psychiatrists, psychologists, GPs, and social workers eat in a different place. One of the sociotherapists told me that it is part of their job to share meals with clients and they are part of the living environment of clients, while other staff members are not. But what is different with Equator is that clients don’t come or leave at the same time. At Equator lunch is treated like a family affair with sociotherapists making sure that rules are respected. At De Vonk mothers with small children have their own tables and children have their own dining room.

After lunch I took a walk in the nearby park with two sociotherapists, and three clients including the man I had spoken to in the morning who told me that actually his really name is Moshe and that he lied immigration officials when he was asked to tell his name. I asked him me whether or not that could be a problem and he told me that it is now 16 years since he is here and he would not have done it if he had been only two weeks in the Netherlands. He told me that when he arrived in the Netherlands for the first time he felt human, something he had never experienced before, he told me that he was on his way to Canada and then the police here in the Netherlands told him to stay, he got his papers and later he was given a Dutch passport. After the walk I was invited to the closing ceremony which was attended by eight clients however, some did not want to talk. Again the same man I had spoken to in the morning told us how he had troubles with young men in the train, they were playing football and spitting everywhere. He tried to stop them but he lost his temper.

The police came in and asked him why he did not inform the people in charge of train but he told the police that they were in another compartment. The sociotherapists talked about how to handle situations such as this one without losing control. After the meeting I went home.
3.4. Therapies other than sociotherapy

In both clinics in addition to sociotherapy, clients attend other therapies either individually or in groups. In this study I will only discuss therapies I either participated in or observed.

3.4.1. Ergotherapy

Ergotherapy in Equator clinic can be compared to creative therapy in De Vonk clinic. In ergotherapy clients do various activities, like painting, drawing, making chess boards, surfing on the internet etc. Basically clients are free to do what they like and feel like doing. According to the ergotherapist the idea behind the therapy is that when people are busy working they cannot think about their problems.

The ergotherapist showed me what they did; a variety of art ranging from cards to paintings. He also told me that they help the clients to use their imagination, for example telling them to think “what kind of road signs would you use if you were the minister of transport?” or “what kind of symbols would use if you were a royal family member?” Looking at what clients come up with using their imagination, the ergotherapist told me that there are certain themes that keep on coming back, such as love, loyalty, and trust. Clients explain the re-occurrence of those elements by saying that one cannot achieve anything in life without love, loyalty and trust.

I realized that some clients do what they really like and take pleasure and pride in it. For instance I found a lady from Iran who was painting what looked a flower and she invited me to join her in painting. Then she told me that back at home she used to paint as well, indeed she seemed to know what she was doing. I also noticed that some clients use the occasion to revisit their past like this man from Afghanistan. He showed me what he had painted previously, which included scenes of war, displaying tanks firing, helicopters flying over the mountains around Kabul, fighter jets, soldiers running with guns, houses on fire and dead people scattered all over the place. He explained to me that the reason he painted those pictures is because that was his experience while in Afghanistan during the war and those images come back to his mind every day. When he is at home he starts writing about it but the doctor has advised him to stop doing that. Nevertheless he told me that he has written a long text about it. In Equator the whole group attends ergotherapy at the same time and it takes approximately one hour every Wednesday.
I attended one creative therapy session in De Vonk. Clients mainly do painting and on a bright sunny day, they can also paint outside. The therapist in charge told me that creative therapy helps clients to regain their concentration and have new ideas in their minds. This is because clients always have those bad memories stuck in their minds. The exercise takes approximately one hour.

3.4.2. Psychomotor therapy and Relaxation therapy

Psychomotor therapy in De Vonk can be compared to relaxation therapy in Equator. In both clinics clients are taken through different body exercises that aim to make them feel better physically. The belief is that if the body feels better it can positively affect the way someone feels mentally. In Equator the therapist urged clients to repeat the same exercise at home every day if they feel that it helps them to feel better, although she warned them that sometimes it doesn’t work or it does not work with everyone. At De Vonk the therapist told me that the aim of the therapy was to identify the positive sides of these people and to help them have some joy, focus, hope and possibilities. He told me that medical doctors focus on sick sides while in psychomotor therapy the aim is to develop the healthy sides so that they can help clients connect with the outside world. I noticed that clients at De Vonk looked more tired during the therapy than the clients at Equator, and the therapist at De Vonk told me that it is because of the medicine they take that weakens them.

3.4.3. Sports

Every Wednesday afternoon at Equator clients have one hour of sports. They play a variety of games, volleyball, badminton, basketball etc. I noticed that most of clients, male and female alike, like this time of sport. Some ran quickly to the sport facilities and started to play even before the person in charge came in. I also noticed that during this time the atmosphere among the clients was even livelier than during other therapy sessions.

3.5. Sociotherapy and cultural differences

Clients in both clinics come from different countries hence they have different cultural backgrounds. These cultural differences were sometimes reflected in the sociotherapy discussions. In this section I highlight some of the issues and incidents that were discussed in sociotherapy resulting from cultural differences.
In Equator clinic, some Christian clients wanted to have a moment of prayer before lunch, but others did not seem comfortable with the idea, therefore the issue was discussed in the group discussion. Some clients had no problem with praying because they always pray in their hearts before eating. For others praying before meals in their culture is done only by the head of the family, while for some any moment of silence reminds them about what they do in their culture during funerals. Every one was given a chance to say what is appropriate in his or her culture in regard to praying before lunch. One of the sociotherapists also asked the group what should be done in order to make every one comfortable as far as the issue of praying before lunch was concerned. Eventually the group came to a compromise that they would have a short moment of silence.

In De Vonk clinic there was an incident that occurred and was dealt with in a meeting that brought clients and sociotherapists and therapists together every Thursday afternoon, the Patient-Staff-Meeting (PSM). A lady from Somalia put a shell in the hair of a small girl but the mother of girl did not know who had done it since the child could not remember who had put the shell in her hair. According to the mother of the girl the shell meant that someone wanted to bewitch her daughter and she reported it to the sociotherapists. According to the lady who put the shell in the hair of the girl, in their culture it is a sign of beauty not witchcraft. The psychiatrist intervened to note that cultural differences can lead to serious misunderstandings. She gave an example of how when she was working in Uganda, she wanted to visit a friend who had fallen sick and wanted to take flowers but people told her that would be interpreted that the friend is dead. The chairperson of the meeting underlined the importance of discussions about cultural differences. The lady who had put the shell in the hair of the girl was deeply sorry because her gesture was misunderstood and not appreciated, yet she meant good. Another mother noted that some of the clients don’t like children and want to harm them. She said that one mother was told by some clients that children make them nervous and she requested that the matter be taken seriously. The psychiatrist again underlined the need to create a culture of safety for children in the clinic.

In another PSM meeting a lady from Somalia said that some of the clients watch TV programs and visit websites that are not good for children. She urged the staff members to do something about it to protect the children. The chair of the meeting asked other clients what they thought about it, and one man said that the views of that woman are Islamic and here they are in the Netherlands and so they are not controlled by Islamic rules and regulations.
Other clients were of the view that if someone is found watching those channels he/she should be told there and then to stop doing that. The psychiatrist told them to proceed like in a family where people agree on what to watch at what time.

In Equator some clients said in a group discussion that they don't like to hear the Afghan people speaking in their language because they don't understand what they are saying. The whole group agreed that it was a relevant point and even the Afghan agreed that it was not good to speak in their mother tongue while they are in Equator clinic.

All in all cultural differences can be a challenge in sociotherapy with refugees coming from different cultural backgrounds. The response that emerges from sociotherapy reflects the relationships between not only sociotherapists and clients but also among the clients themselves and it may have influence of the meaning clients give to trust.

3.6. Sociotherapy in a mental health clinic: Clients-Sociotherapists interactions, a reflection of agency and power relations

As I mentioned earlier, my experience with sociotherapy in Rwanda influenced the way I viewed and experienced sociotherapy in both clinics in the Netherlands. As Zaman pointed out, “We cannot rid ourselves of our experiences. We can however, become aware of our experiences, our opinions and our values. As a result, bias is a human condition, a danger for both insider and outsider researcher.” (2004:37). In Rwanda people talk about sociotherapy according to the way they have experienced it. For some it is a medicine, for others it is a training, others see it as teachings, for others it is counseling. The same understanding applies to sociotherapists, for some they are teachers, advisers, counselors, pastors, friends or even professors. Sociotherapy is diversely understood not only because of the individual experiences but also because sociotherapy is not tied to one topic or aspect of life. The understanding of sociotherapy by individual Rwandans is determined by the expectations and the outcomes they have before and at the end of the program. Beneficiaries come to sociotherapy with certain identities and how they use them influence both the nature of discussions that take place in sociotherapy groups and the dynamism of interactions between sociotherapists and the beneficiaries.
For instance, when ex-prisoners are invited to join sociotherapy they come with identities they got for having been in prison, such as "killers," "animals," "genocidaires". Consequently at the beginning of the program they are hesitant, suspicious, and very careful in the way they talk. Ex-prisoners are concerned about their image that has been tarnished by imprisonment. They think that no one believes or trusts them, and they desperately need a way out of that predicament. Sociotherapy offers them a social platform to reclaim their rightful place in the community. Nevertheless it is with these identities that they seek advice from sociotherapists, request sociotherapists to ask or do things on their behalf, or test their commitment and trust by asking them to visit their homes for instance. In brief it is with the images of bad people such as, killers, witches etc. that the ex-prisoners explore multiple facets of sociotherapy. In both clinics, as in Rwanda, sociotherapy encompasses many facets of the refugees daily lives and this is indicated by the issues that clients raise, their concerns and expectations and the responses they get from sociotherapists.

In Equator the emphasis is on creating a family like condition. Scholte said that he wanted the sitting room to be like a living room because the group should be like a family. In psychiatry people are against having comfortable couches because clients will lie on them and be passive, but in Equator they did the opposite in order to create a family living environment. The idea of a family is underlined during lunch time when all the clients and sociotherapists eat together as a family.

Another sociotherapist told me about her relationships with clients. She said that sometimes older men treat her like their daughter and act as though they are her father and according to her having someone like her in that role gives them peace. With the emphasis on the idea of a family, sociotherapists take on the role of parents, who oversee the rules of the family and this becomes evident when clients speak a language other than Dutch.

The idea of a family gives the clients the position of children, people who have to learn, and this is underlined by issues they bring to sociotherapists such as telephone bills, reading letters for them, making telephone calls for them, how to use family money, or how to get a new house. Even when sociotherapists do not have the competence to comply, clients are excused, understood, sympathized with, because they don’t know.

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4 These are terms that commonly used in Rwanda to refer to someone who is alleged to have been involved in genocide of 1994.
Sociotherapists argue that the Netherlands is a more complex society than societies where refugees come from. In the Netherlands, there are many institutions running independently and it is important for every one living in the country to know how they work and how one can solicit their services. Refugees don’t know because of the language barrier as well as spending many years in the AZC. That is why, on many occasions, sociotherapists in group discussions introduce clients to the social, political and economic aspects of the Dutch society.

On the other hand this relationship between clients and sociotherapists, highlights the issue of power relations. Sociotherapists are portrayed as people who know, control and can decide, even though in sociotherapy no one decides for the other and the view of every one is equally treated. Being treated like children gives clients the freedom to bring up any issue and to test the commitment of the sociotherapists. In brief it allows the refugees the freedom to exercise their agency. Sandstrom et al. argue “that freedom is always linked with social structure and constraints” (2006:19).

In De Vonk clinic clients are in better living conditions compared to AZC. The sociotherapists strive to give them a convenient social environment to recreate connections with others. One sociotherapist told me that people come here when they are very isolated, they don’t connect any more and when they come to the clinic and live with people with similar problems they see it as a kind of recognition.

Given the living conditions in AZC and the mental health problems of the clients, staying in De Vonk is a privilege one gets on the merit of being sick. That is why some clients who are laughing when they see sociotherapists will stop to give an impression of being very sick. One sociotherapist told me that he always tells them that they don’t have to play that game because he knows that even if someone is laughing it does not mean that he/she doesn’t have any nightmares or any other pain.

Clients think that if sociotherapists see them laughing they will think that they are strong and don’t need the clinic any more. But sociotherapists know that the clients may still have pain and suffering inside. The clients know and hope that they can use their sickness to help their case in relation to their uncertain future in the Netherlands as many still live in AZC waiting for the decision to stay in the country or sent back home.
One staff member told me that sometimes they gain something from being sick, for example staying here, it may not be out of bad faith, but it is just a survival tactic if their countries are torn by wars.

This may justify why some staff members have doubts about what clients claim about their sickness as one told me “if one reads their story, their stories are things they tell, one doesn’t know whether it is true but one assumes that it is true.”

Nevertheless it can be argued that clients are aware of the issue of their power relations with the staff members and they want to use it in their favor. While talking about lying in a doctor-patient relationships Fainzang (2005: 48) points out that in this relationship power is given to the doctor and denied to the patient, therefore the lying of the patient expresses his way of taking power away from the doctor.

In the light of the above remarks, the interactions between the sociotherapists and the clients at De Vonk clinic highlight the issue of power relations. Sociotherapists have the power to control and decide vis-à-vis their relations with clients on the other hand clients use their sickness to influence the interactions with sociotherapists and exercise their agency both in and beyond the clinic.

3.7. Conclusion

This chapter provided a detailed account of a day experience in sociotherapy with refugees both in Equator and De Vonk clinic. The chapter has also highlighted different facets of sociotherapists by focusing on interactions between sociotherapists and clients in terms of group and individual conversations. There was a description of the nature of interactions as determined by the topics of discussions and how both sociotherapists and clients view the discussions; in this respect this chapter emphasized cultural differences. Against this background the question for the next chapter is how do these interactions between sociotherapists and clients influence trust? Also, what is the meaning clients give to that trust? The next chapter will start with three case studies and a theoretical understanding of trust by refugees will be developed.
CHAPTER FOUR

GIVING MEANING TO TRUST: A THEORETICAL UNDERSTANDING OF REFUGEES' PERSPECTIVES

4.1. Introduction

Sociotherapists stress that trust is a significant component of sociotherapy. At the Equator and De Vonk clinics sociotherapists argue that in order to work with refugees in any way, they must establish trust with the refugees. One sociotherapist told me that trust is the first point that one should try to establish with a client so that they feel comfortable, trusted and respected. In the light of the paramount importance of trust in sociotherapy, this chapter aims to understand the meaning refugees, who are experiencing sociotherapy, give to trust using certain theoretical concepts. The theoretical analysis of the refugees' perspectives on trust will consider the process of sociotherapy in clinics of traumatized refugees in addition to the whole process of being a refugee. The theoretical analysis will be based on the findings that are presented in chapter three as well as in the following vignettes which are a selection of three cases⁵ that give detailed profiles of the life of individual refugees. The vignettes highlight the three individuals' lives in their countries of origin, their lives as refugees in the Netherlands, and their impression about the experience of participating in sociotherapy. Using the concepts of control, agency and power this chapter attempts to demonstrate that trust is an essential and 'existential' dimension of human relationships. The analysis I will present is based on story telling which is an essential aspect of the life of refugees in general and those participating in sociotherapy in particular. This chapter also uses the concept of expectations to show that trust is the goal, the product, of the process of sociotherapy.

⁵ It is important to note that these three cases and other interviews I refer to in this thesis form small number of case studies which may not be representative to draw general conclusions.
Case 1: Mr. P

Mr. P is a 41 year old man, he has been living here in the Netherlands for 16 years. He left school when he was 13 years old and became a child soldier, but he wanted to study; being a soldier was never his choice. He saw many of his friends being killed. It was only when his best friend was killed that he put his gun down in front of his superior and ran away. He decided to leave because he could not see any future and he still doesn’t see a future; no one is prepared to build his country, only to abuse human rights. He left his country in 1990 but arrived in the Netherlands in 1992.

When he arrived in the Netherlands for the first time in his entire life he felt like a human being. He feels at home here in the Netherlands and doesn’t feel like a refugee at all. On the contrary he felt like a refugee in his home country. From the day he asked for asylum here they took care of him, in terms of medical care, the possibility to study and to work. Mr. P studied the Dutch language then worked as a translator, a barman and salesman. He is divorced but his three children and his ex-wife live in the Netherlands as do his mother, brothers and uncles. For this reason he considers the Netherlands his country now. Mr. P is in De Vonk clinic because when he was a child, he lost his father. They shot him in front of the family. That was the first time he saw blood and after he became a soldier he never saw good things. All his experiences were bad. Therefore he has nightmares and is suicidal. His boss thinks he is fine and he can work because he looks physically fine, but his problem is that when he works he doesn’t know how to set limits; he wants to do every thing and has conflicts with his colleagues. He is concerned about his short temper since when he gets angry he breaks things. He doesn’t know what happiness is; nothing makes him happy. Mr. P was sent to De Vonk clinic by his GP.

At De Vonk, they know and understand his wounds, they listen to him and they don’t judge him. They listen to him and try to find solutions to his problem by giving him activities to do, talking with him, and with medicine. He doesn’t have to sit in his room alone thinking; the staff knows that and they go to him, they are polite and professional. He acknowledges that it is difficult for sociotherapists to work with people who are always sad, without hope, but they are diplomats so they can work in any hospital. They can manage anything, he has great respect for them.
They taught him how to talk and told him that if you don’t talk you don’t get help. He has good relationships with people at De Vonk, because they understand and listen to him. People with post traumatic stress, like Mr. P need understanding. Often if one admits to having been a soldier the first question other people ask is, “did you kill people?” But at De Vonk they have never asked him that question, they know he was a soldier, but never asked him whether he killed someone. De Vonk clinic is special, all the doctors and nurses (sociotherapists) let him talk and they listen. Unlike other clinics who only gave him medicine that made him numb, De Vonk has other strategies. For the first time he is going to complete his treatment. He has been in other clinics before but left prematurely. He became known at other clinics as someone who does not complete his treatment. Mr. P has trouble finishing things he starts, even studies. He would pay for a year but leave before school ended; he had trouble with concentration. But at De Vonk he was knitting a carpet was looking forward to finishing in July. Now he can now find things that make him happy, he goes to a movie with another client, he watches football, and he cycles.

Before he came to the Netherlands he did not know trust, he knew two things, enemy and friend; he did not know the word trust and never used it. Now for him trust is a process that grows; you have more trust or less trust. If he tells someone his story in his room and he hears the story repeated that means that trust is abused or if he tells a story and he is judged by it the trust is gone. But when he meets you for the first time, and the second time you have done nothing with his story and you support him, trust increases. Trust means a lot to him. He trusts his father-in-law. He allows his father-in-law to be with his children. He can tell him all about his feelings whether he is happy or sad, whether he has or doesn’t have money. He trusts the Dutch because they accepted him, gave him a passport and now he has the same rights as any other Dutch citizen. Not to trust is also human and he gave an example of how one day his mentor was asking him questions as he filled the form upon his arrival at De Vonk clinic. He thought that the mentor was a detective working for the police, and when he accused the mentor of being a detective, the mentor was shocked, but Mr. P thought the problem was in him not the mentor. The mentor assured him that he was not working for the police, that he was doing his job, and from that moment on Mr. P decided to trust him and they both talked about it and now they trust each other.
Case 2. Mss. M

Mss. M is a 36 year old woman, she has been living in the Netherlands for the last eight years. She has a high school diploma and no job. The troubles of Mss M started when her father died when she was only one and a half years old. When she was nine years old her brother was arrested. After five years her brother was killed, officially they said that it was an accident, but she is convinced that they killed him because he had not transformed into the ‘good’ person they expected him to be. After the death of her brother her mother developed a brain and heart disease. She has never had a childhood, and now she is writing a poem that she has called “Where is my childhood?”.

The main reason Mss M came to the Netherlands is political as her whole family is politically active. The journey to the Netherlands was long. She spent eight years in AZC and the conditions there were bad. She was put in the same room with someone who smoked opium and she was always so afraid that she would not even go to the toilet at night. The room was so small with no air-conditioning. There was moisture on her clothes and when she asked the people who were responsible for the air conditioning to turn it on, they did not do it. She bought a bicycle to help with transport and when it was stolen she reported it. However, the people in charge of AZC and the police did not help to find it.

She talked about her problem with another doctor who eventually referred her to a psychiatrist in AMC and he sent her to Equator clinic. She comes to Equator three times a week but she thinks that it is not enough. She feels tired, and sometimes she sees herself dead in a coffin. Mss M also thinks that the fact that she doesn’t have a house of her own yet makes her problems worse.

Sometimes she lives with her boyfriend and other times she lives in AZC. When her colleagues see her taking medicine they tease her saying that she will have cancer when she gets old. She thinks that if she could get a house of her own every thing would be okay. She believes that she should have a house on medical grounds, but for unknown reasons someone removed her name from the priority list.

Mss. M does not trust the Dutch at all. She says that trusting people is not good a thing. She has a feeling that when a person comes to her and says something she thinks that is true but later realizes that it is not true. Each time she faced the problem of people not telling her the truth and now she thinks that is not a good thing to trust. She has faced many negative experiences while trusting people. Even at work in her home country she tried her best, she liked her job, but sometimes she saw distrust in people.
Her past experiences have influenced her understanding of trust and she thinks that her mind is dead because of her mistrust of people.

Nevertheless Ms. M said that when she went to Equator for the first day she was told that all the clients are like one family and so in general she has a good feeling. Her mental sensation works well, although she still has difficulty communicating with the group. Although she does think that at the end of the sociotherapy she will have good relationships with people in spite of her communication problems, and she is trying hard.

Case 3: Z.

Mr. Z is a 26 year old man, he has been living in the Netherlands for seven years. He has a high school diploma and he did studied pedagogy but could not finish because of the war. When the war broke out it was very difficult, he did not know what to do or which direction to take. He came to the Netherlands without a passport. He paid a smuggler a lot of money to bring him to the Netherlands.

When he arrived in Netherlands he spent six months in Onderzoek Centrum (OC) before being sent to AZC. He lived in two AZCs, first in Groningen then in another, and it was very hard for him. Life was tough in AZC because he could not speak Dutch as he does now in sociotherapy. He can say what he wants with other clients and sociotherapists at Equator, but in AZC he could not do that. Moreover in AZC people come from many other countries and some of the residents are good while others are not good; as it was the case in his home country. The war and other problems were the only world he had known before coming to the Netherlands. Life in AZC was different but nothing like what he had known in his home country.

He expected the Dutch to be kind, and most of them are. He wished to learn the language and he did it. He asked the Dutch government the permission to stay and he was allowed to stay. But the most important thing in his mind was to speak the Dutch language. When he first came to the Netherlands there was a strange government policy about refugees and he was not sure whether he was going to stay or not. However, last year he got his permission to stay after six years. All the time he was in AZC Mr. Z felt that life was unfair because he did not have any rights here in the Netherlands, no house, nothing. Even when he left AZC he did not have a house and instead he moved from one hospital to another for treatment. He was very angry with the Dutch people, but he feels that rules are rules and they have to be respected.
Mr. Z came to the Equator from another hospital where a psychiatrist told him that there is a program, sociotherapy, which could be good for him. Mr. Z's problems are nightmares and he feels bad most of the time; he has headaches. Sometimes he feels that he would be better off dead. He has post traumatic stress disorder (PTSD) as he always re-experiences the war. Mr. Z goes to sociotherapy three times a week and is not sure if or how sociotherapy helps him with his problems.

For Mr. Z trust means that he can say everything and anything to a person. In his home country trust did not mean anything there because there was war. he did not have to think about trust at all, there were a lot of problems. He said that here in the Netherlands, he talks to people, he trusts them. Sometimes he doesn’t trust people, it depends of course, but most of the time he trusts people. Mr. Z knows when there is trust because of the feelings he gets. In Equator he trusts people because he knows everyone is there to help him, the psychiatrist, the psychologist and he can tell them his problems. He knows why they are there and that is why he can trust them. He thinks that all the people in Equator are kind, but that does not mean that you can trust everyone who is kind. Sometimes when people are kind and they want to have friendship but when they have it they can easily use you or misuse you for other things. Mr. Z believes that when someone is kind and wants to be a friend it is not a guarantee that you can trust him. First he can see it in the person’s eyes, then he feels it in his heart that he can trust someone. In his home country people don’t trust quickly because people act as if they are kind and then they misuse the trust in the war. He had to be careful, if he does not have a chance to look in a person’s eyes. When he meets a person for the first time and the person asks a lot of questions he starts to wonder why and then he cannot trust that person.

Mr. Z is now a Christian and has good relations the church. He thinks that the church is good for trust and that in religion it is easier to trust people especially when you know that they are from the church. Aside from the church and Equator Mr. Z doesn’t have any other relationships.

4.2. Refugeehood, it is all about telling one’s story: Regaining control, agency and power.

4.2.1. Trust is an essential and ‘existential’ dimension of human relationships.

Sociotherapy is one area where human relationships are deemed crucial. A relationship is by its very nature ongoing and dynamic and trust is considered to be an essential and ‘existential’
dimension of that dynamic relationship (Flores & Solomon 1998). This understanding of trust inspired the following theoretical analysis. In the following section I will examine what trust means to refugees, in light of what is considered important aspects of their lives of refugees namely story telling.

4.2.1.1. The paradox of story telling

The idea of refugeehood is a paradox that hinges on telling one's story. On the one hand, for refugees to tell their story is a need like any other. Jackson (2006:93) has pointed out

Refugee, stories are driven by existential need rather than emotion, epistemology, eschatology, or ethics. By this I mean that they do not tell us what we may know, what we may believe, how we may judge, or how we may feel; they attest to the fact that telling stories is, like our need to breathe or defecate.

Because of the dire situations of refugees, their stories are not like stories other people ordinarily tell. Some would argue that refugees don't have the words or that no language is adequate to accurately and coherently express their experience in stories as a person in normal circumstances would. Nevertheless there is the need for refugees to tell their story as "the reward of story telling is to let go." (Jackson 2006:103).

The paradox of refugeehood story telling is that one has to tell his/her story to let it go and on the other hand there must be "the" story that one has to have and tell consistently in order to be recognized as a refugee. As Cieslik and Jura (2002:135) illustrate, for someone to become a refugee in the Netherlands he/she needs to have a story to tell, "the only solution is-a lie. Make up a story, a story that you can remember, so that you won’t make mistakes. Those who, honestly say ‘I don’t remember’, don’t stand a chance."

Therefore the quandary of refugees may not only be about the loss of words to narrate their experiences, but also to have their story consistently treated with skepticism and indifference by the officials in the host countries. Understandably, this is a concern for refugees and more so for traumatized refugees who would find it ironic and cruel that they have to answer with precision the dates and places of their experiences in order to authenticate their stories in the eyes of their receiving administration, because refugees, some would argue are incapable of recollecting this kind of details (Jackson 2006).

In brief, the act of telling one’s story, for refugees, is meeting a human need like any other as it helps them deal with the past by letting go. At the same time one becomes officially a
refugee by telling his/her story but the story is treated skeptically and with indifference, compelling the storyteller to make up a story to overcome the skeptics. It is these two faces of story telling that makes it a paradox for refugees. The question is how does this paradox relate to the meaning refugees give to trust? And how does it relate to sociotherapy?

4. 2.1.2 Trust, story telling and regaining control.

In sociotherapy talking either in individual or group discussions is one of the main activities. We have just seen that for refugees narrating their experiences is crucial. The only difference is that when refugees tell their stories in sociotherapy they are listened to and not questioned, treated skeptically or with indifference. As in case 1 Mr. P said that they are professionals, they listen to you and don’t judge people by their stories. There is no skepticism or indifference, in other words the clients tell their stories without having to stretch their limits in words and languages by making up a story. Flores and Solomon (1998: 218) argue “trust is created through dialogue, in conversation, by the way of promises, commitments, offers, demands, expectations and explicit and tacit understandings.” This means that allowing refugees to talk and discuss their problems in a more human and friendly way creates trust between refugees and sociotherapist and that trust develops making their relationships dynamic.

For sociotherapists trust means a beginning of talking, opening up, getting closer and sharing ideas and personal experiences with the group. One sociotherapist told me that trust for them means connecting with clients by getting them talking, let them asking questions, having them sharing intimate experiences of the past.

For the refugees, trust means telling their stories and being listened to. Sociotherapy offers the possibility to share their experiences with someone to listen, including open time and space. The difference between speaking with sociotherapists or immigration officials is that with sociotherapists the refugees can tell their real experiences or as one sociotherapist told me, their (refugees) stories are their truth.

In other words, what they say happened, is their true experience. Thus in sociotherapy refugees don’t have to make up a story or lie. Whatever they say or however they say it is not and will not be questioned, doubted or treated with indifference or used to judge them.
The refugees have that assurance from the beginning. Mr. P in case 1 says that when other people know that one was a soldier, the first question they ask “did you kill people?” But at De Vonk he says they never asked him that, yet they know that he was a soldier. Moreover in handling the incident of the shell the sociotherapists listened to both ladies and never took a side. On the contrary, they let the mother of the girl and the lady who had put the shell in her hair as a form of adornment, each tell their version of the story without judging them on the basis of their stories.

It is important to note that what takes place in sociotherapy is in total contrast to what refugees must endure while in being interviewed by the Immigratie- en Naturalisatiedienst officials (IND). The officials of IND suspect everything, questioning every detail of the refugees’ stories or the particulars of a situation. This means that any moment of hesitancy or fogginess associated with remembering are considered as signs of lying. Ironically a liar who has thought up a pitiful and thorough story often appears more convincing. (Cieslik and Jura 2000).

I would argue that for refugees in sociotherapy trust means re-owning their experiences through telling their story to a non-skeptical audience. The story they tell officials to be guaranteed refugees status, does not belong to them, it belongs to those who want to be convinced by it. As this man told me, “this is not my name, my real name is Moshe”.

This was an indication that as he talked to me using his real name, he was rediscovering/re-owning his past experiences. Mss M in case 2 is trying to understand her lost childhood. It can be argued that in Equator clinic she was enabled to revisit and indeed re-own and talk about her past, which she had never been able to do before.

Sociotherapists both at Equator and De Vonk told me that right from the beginning they strive to establish trust with the clients by showing them transparency, openness, giving them space and time to adjust, making them feel welcome, or being predictable with them. It is these attitudes and behaviors that assure the clients that they can tell their stories differently or indeed different stories that carry their real experiences. As Mr. P told me about the staff saying that “they are professional, they are polite, they listen to us”. Mr. Z says that all people in Equator are kind, he trusts them, because he knows that they are there to help him, therefore he can tell them his problems.
I also argue that the behavior of the sociotherapists indicates to refugees that not only the stories they are telling will not be questioned but also they are in control of the story telling process and in control of the audience. This is not the same as when they are interviewed by IND officials. I argue briefly that for refugees trust means re-gaining control of story telling.

Writing about control and its forms, Maguire et al. (2001) note that for the sake of linkage between trust and control, they assume that the object of control is individual or organizational behavior. In this study, organizational behavior is understood as a code of conduct in both clinics for sociotherapists and other therapists as they work with refugees. For instance no sociotherapist is allowed to have intimate relationship with a client.

Furthermore Maguire et al. (2001) name two ideal types of control. The first is coercive/remunerative control, achieved through rewards and punishment, a contract is cited as a common example of this type of control. The second is normative control. In the light of what is discussed above in terms of the behavior of sociotherapists and the responses of clients give in feeling that they re-own their stories and control the process, this study suggests that the type of control that clients get in sociotherapy is normative. Because with normative control the actors’ behavior is obedient for they believe it is the right and natural thing to do.

Similarly, Falcone and Castelfranchi (2002) wrote about the dynamics of trust-control relationships and argue that the end point of control is to improve the trust that the trustor has in the trustee because the aim of control is to increase the reliability of the trustee in terms of fidelity, willingness, keeping promises, etc.

It is worth mentioning that one of the things that you hear from the sociotherapists when they talk about their relationships with refugees is that when they promise to do something for refugees, like arranging a meeting with a doctor or another person, they have to do it. Any failure would be damaging for the therapist’s reliability and integrity and would brush way or decrease the trust the clients had. It can be argued that in trying to assert their reliability, sociotherapists hand over the control to clients and hence improve the trust that exists between sociotherapists and refugees.
4.2.1.3. Story telling as: Agency and power.

This study argues that by regaining control clients can exercise their agency in sociotherapy. Agency is understood here as “forms of power people have at their disposal, their ability to act on their own behalf, influence other people and events, and maintain some kind of control in their own lives. Agency in this sense is relevant for both domination and resistance.” (Ortner 2005:20).

In the light of the above definition, I would argue that by regaining control in sociotherapy refugees are enabled to act and influence decisions and outcomes in both individual and group discussions as well as other actions that take place in sociotherapy. Through telling stories of experiencing political violence in their home countries, unpleasant experiences with unsympathetic immigration officials, and difficult times in AZCs, refugees earn sympathy, recognition and respect from sociotherapists and other therapists.

Sociotherapy enables refugees to get recognition as innocent victims who deserve better treatment and respect from a public that is generally hostile towards immigrants. A refugee from Iran told me that once he told sociotherapists a story about how long ago the prince and the princess of Iran came to the rescue of the Netherlands when they were about to be submerged by water. The idea behind the story was to let them know that he is from a rich and proud cultural background and he should be treated respectfully. He said, “I am not a small person, we have a good historical background.”

It is quite common, and it happens in sociotherapy as well, that refugees tell their personal stories to show how important they were in their home countries: professors in the university, engineers, lawyers, high ranked government officials, high ranked military officers etc. It could be argued that refugees use that kind of story to dispel the general view that they are here to benefit from the Dutch society. Since they were better off back at home, they want to be treated with respect and dignity. Refugees use their stories to manipulate decision-making structures in their favor. I have talked to two clients whose problems were the lack of their own accommodation. So they used stories of fatigue, headache and sleeplessness to further their case for accommodation.

Giddens (1984) argues that to be an agent is to be able to deploy a range of causal power, including that of influencing those deployed by others, and one stops to be an agent when he/she cannot exercise some sort of power. It can be argued that in sociotherapy refugees...
rediscover their powers. There are many views about what power means; some perceive power as a quality of the relationship in which both parties influence the other. Others view power as the capacity to affect the outcomes of oneself, others, and the environment (Johnson and Johnson 2006). By enabling refugees to act as agents, sociotherapy enables them to rediscover and exercise their powers. Refugees have power to influence the relationships they have in sociotherapy hence it has an influence on what trust means. It can also be said that the link between regaining control and acting as agent implies that through their telling their stories in sociotherapy refugees are enabled to exercise their power.

4.3. Sociotherapy with traumatized refugees: Trust and high expectations

Using the paradox of storytelling I showed how trust is a dynamic aspect of relationships that is created and develops through story telling and conversation in sociotherapy between clients and sociotherapists. I also used the paradox of storytelling to show what trust means to refugees who are participating in sociotherapy. In the following section I will attempt to show how in sociotherapy trust is seen as a goal and what the refugees think that means from their perspective. Flores and Solomon (1998:222) argue, “trust is borne in and of relationships.” To show how trust is viewed as a result of relationships in sociotherapy, I will explain it in relation to the expectations of clients. In this section, I will take into consideration the fact the clients are not only refugees but traumatized refugees who are still struggling to find their way in the Netherlands. In this section, we refer to the definitions of trust in chapter one where the relationships between trust and expectations and behavior is emphasized.

If we assume that refugees are trustors and their expectations depend on the behaviors of sociotherapists, then the link between behavior and expectation would determine what trust means to refugees. The question is: how does that link play out in the experience of Equator and De Vonk clinic?

As I hinted in the previous chapter, when clients at Equator start to come in to the room or when they are having coffee/tea or having a discussion with sociotherapists, as a visitor, first you wonder who is a client, who is not or what could be wrong with these people? Even when you start to find out what their problems are and the issues they raise in the group or individual discussions you still wonder how do the clients view the program and what do they expect from sociotherapy?
At De Vonk in spite of some organizational differences with Equator, the realities are more or less the same. Some clients look dull but other look normal. The question remains the same, what do traumatized refugees expect from sociotherapy?

In this study trust is viewed both as a dynamic aspect of human relationship and a goal in sociotherapy. For the clients trust as goal of sociotherapy is seen in terms of their expectations. In sociotherapy the behavior of sociotherapists invite clients to set their positives expectations because they believe that the former have their best interest at heart (Hall 2002). On one hand sociotherapists strive to be open, transparent, good listeners, predictable, controllable etc... on the other hand, clients describe them as kind, professionals, polite etc... and this could explain the expectations of the clients for the sociotherapists in both clinics.

In the case of Mr. P at De Vonk, for the first time he is looking forward to finishing his treatment. He has been in many clinics and never completed the treatment there. At De Vonk he was looking forward to finishing the carpet he was knitting, something never did before and he was starting to find some happiness for the first time in his life. Looking at what Mr. P is looking forward to achieve and how he describes the conduct of the sociotherapists at De Vonk, we can deduce that the trust he has in his mentor and other sociotherapists and other therapists is based on the interdependence between his expectations and the conduct of the sociotherapists he describes with the above adjectives.

At Equator clinic one of the main objectives is to make the group look and feel like a family. As described in the previous chapter, the sociotherapist ensures that this feeling takes place by displaying openness, transparence and kindness and by ensuring that the group eats together like a family whose members are treated equally and respected. There is a case of lady who was raped but she spoke about it for the first time in one of the clinics, something she had not even discussed with her family. Mss M. still has communication problems but she feels that her mental sensations are better and she is looking forward to better relationships with people at the end of the program. The same situation applies for Mr. Z who says that outside the church and people at Equator he doesn’t have any other relationships.
It could also be argued that based on the behavior of the sociotherapists clients expect them to deal with anything they bring to them. This could include telephone bills, making phone calls for them, finding houses for them or even legal or administrative matters that concern other institutions like decisions whether they stay or leave the Netherlands. Sociotherapists told me that when such things happen and they as sociotherapists are not able to meet the expectations of the clients, the latter are disappointed and it affects the trust between the two parties. One sociotherapist told me that clients tell her to give them one magic pill that will take away all their problems, but when she tells them that such magic pill does not exist they are very disappointed. This can also explain the dilemma of the man from Iraq who kept telling me, “I don’t understand these people” when the house he was looking for was not forthcoming. The same occurred for Mss M who thinks that with a house of her own her problems will ease up. This is all because the sociotherapists have behaved in a way that tells clients that they are there with good intentions; something refugees may not have had before and consequently the refugees set their expectations very high, irrespective of their ability to monitor or control the other party (Lewciki et al. 1998).

All in all it is important to note that trust is not only a result of verbal interactions but also of physical and bodily contacts, as Flores and Solomon (1998: 219) put it, “There is a good deal of trust embodied in our mere physical presence to one another, in our gesture, looks, smiles, handshakes and touches.”. It is equally important to mention that this is an aspect of interaction that sociotherapists in both clinics use regularly with refugees using gestures such as smiles, looks, and handshakes.

4.4. Conclusion

This chapter examined what trust means to refugees who are participating in sociotherapy in both Equator and De Vonk. Using three case vignettes this chapter illustrated a life journey of a refugee from his/her country of origin until he/she arrives in the Netherlands and starts to participate in sociotherapy. This chapter also used theoretical concepts to interpret what trust means to refugees given the fact that trust is both seen as a dynamic aspect that is created and develops in relationships and stands as one of the primary goals of sociotherapy.

The interpretation of what trust means to refugees in sociotherapy takes into consideration some key components of refugeehood, namely story telling and expectations. Using the paradox of story telling this chapter demonstrates that for a refugee telling one’s story is both
a need and an absolute must do activity. Nevertheless while participating in sociotherapy, refugees rediscover their true story that reflects their experiences and they are able to regain the control of telling their story. Through this action they are enabled to act as agents and hence exercise their power. This chapter also showed that when sociotherapists behave in ways that indicate to clients that they intend to do good things for them, the latter set their expectations high. In other words, their trust depends very much on the conduct of the sociotherapists and in this regard both clients and sociotherapists have trust as a goal but on different terms.
CHAPTER FIVE
CONCLUSION AND REFLECTIONS

5.1. Introduction

To conclude this dissertation that investigated what trust means to refugees who go through sociotherapy in Equator and De Vonk clinics in the Netherlands, this chapter presents a recapitulation of the findings in consideration of the main objective and research questions. In addition it reflects on the analysis and further questions that were raised in this study.

At the beginning of this thesis, I mentioned that one of my main motives for doing this study about sociotherapy and trust here in the Netherlands was my personal involvement in a community-based sociotherapy program in my home country, Rwanda. It is worth noting that throughout my fieldwork and thesis writing my Rwanda experience had a significant influence in making comparisons between Rwanda and the Netherlands and raising questions based on that comparison. Likewise I will use my background in sociotherapy in Rwanda to present the final remarks of this thesis.

5.2. Sociotherapy: Dilemma and Paradox

In recent decades the Netherlands has been changing from one of the most welcoming societies to one of the strictest societies in the western world for immigration. Having suffered from various forms of political violence in their home countries, refugees in the Netherlands and elsewhere in Europe are welcomed by an unfriendly combination of public hostility and government restrictions (Weinstein & Stover 2002:305). The process of government officials handling refugees' dossiers is getting longer and tougher and studies have shown that it is bound to have a toll on the psychological state of the refugees who live with uncertainty and stress (Weinstein and Stover 2002: 307). Therefore, sociotherapy like other therapeutic services offered to refugees and asylum seekers here in the Netherlands are caught in the crossfire between politics and policies.

Sociotherapy plays a center role in both clinics, Equator and De Vonk. Sociotherapists know the clients better than any one else. They spend more time with clients than any other therapists. Nevertheless, as in Rwanda, sociotherapy is not defined by one activity or confined to one aspect of life. On the contrary the openness and the flexibility make sociotherapy a ‘hammock’ for developing trust and a road to recovering to normal life.
This is evidenced by various activities and other forms of interactions between the clients and sociotherapists and among the clients themselves. Indeed if sociotherapy fails to give to the clients a meaningful way of ‘living together’, ‘working together’ and ‘spending free time together’ within the hospital setting, then the clinical admission usually has negative consequences for the client, and the other specific therapies are also of little use or profit (Foundation Centrum ’45 2008).

One of the earliest writers on the development therapeutic community from which sociotherapy developed noted that one of the intentions was to make the hospital as much like the ordinary world as possible (Rapoport 1960). It can, however, also be argued that the opposite is possible, as sociotherapy takes what would be extraordinary into the ordinary world of traumatized people. As I mentioned in chapter three, especially in Equator clinic, the setting of the sitting room, the facilities, the appearance of the clients and the conduct of both sociotherapists and the clients give the impression of an extraordinary life in a psychiatric wing of a hospital.

People who work with refugees, whether medical doctors, psychiatrists, or sociotherapists argue that there must be trust in order to work and help refugees. The main question of this study was to understand what trust actually means to the refugees who participate in sociotherapy the program, since trust is so important in sociotherapy. Drawing on other studies this study acknowledges that trust is important for individuals as well as organizational interactions, such as enabling cooperative behavior, reducing harmful conflict, promoting network relations etc. On the other hand there is common agreement that there is no single universally accepted definition of trust. Indeed in this study it became evident that the understanding of trust is a reflection of one’s personal and past experience, coupled with the interpretation of the behavior that surrounds a person and one’s expectations.

In an attempt to understand what trust means, this study has perceived trust as both a dynamic aspect of human relationships created and developed in sociotherapy and a goal of sociotherapy. This study considered that which is equally important in the lives of refugees, namely story telling and expectations. This information helped me to understand what trust meant to the refugees in sociotherapy.
Story telling is an important aspect of refugeehood. For a refugee telling one’s story is a need like any other ordinary need, it helps one deal with the past experience by letting it go. However, one can only become an officially accepted refugee by telling his/her story. Generally this will not be one’s real story of past experience but a made up story to convince the officials. As one refugee summarized “if you tell the truth, you’re out. If you lie, you’re in.” (Cieslik and Jura 2002:137). When refugees come to sociotherapy their need to tell their story is met, they are given a listening ear, time and space to tell their story, and more importantly the behavior of the sociotherapists signifies to refugees that they can tell a story that owns their past experience. They don’t need to make one up.

So trust for refugees means not just telling their story but re-owing or rediscovering their past experiences and in doing so refugees regain control of story telling, agency and power. Drawing on existing literature (Maguire et al. 2001, Falcone & Castelfranchi 2002) about control and trust this study has established once again that it is the behavior of sociotherapists that indicates to refugees that they have now the control of telling their story; that their stories will be listened to sympathetically, respectfully and without skepticism, something they did not experience while going through the process of becoming refugees. Sociotherapists say that while dealing with clients, they are open, transparent, no judgmental, predictable, controllable, patient etc.

During sociotherapy refugees set their expectations high. This study attempted to show how expectations of the refugees and the conduct of sociotherapists relate to the trust the former may have in the latter. In this case trust is perceived as a goal of sociotherapy. Reacting to the behavior of the sociotherapists, clients would set their expectations even higher, like asking for a magic pill that would kill all their problems and pain or for help dealing with medical, legal or administrative matters that are beyond the competence of sociotherapists. The failure to meet these expectations may mean that refugees lose trust in the sociotherapists.
5.3. Reflections

There are many factors that make the experience of sociotherapy in Rwanda different from the experience of sociotherapy in the Netherlands. The two social contexts are different in the sense that in Rwanda the world view is more socio-centric while the Netherlands it is more individualistic. There are differences in facilities and the milieu of applying sociotherapy and differences in the type of beneficiaries. Nevertheless my experience in both contexts has shown that sociotherapy is a multifaceted approach that leads its beneficiaries to rediscover normal life. The behavior of sociotherapists with clients makes it both easy and difficult to know what sociotherapy is and what its limits are. For instance, in both Rwanda and the Netherlands, sociotherapists are teachers, advisers, friends, parents, counselors, mentors, nurses, confidants, etc.

As in Rwanda trust for refugees is not an abstract philosophical concept. It is a reflection of their past, an essential dimension of the present and the future. Some of the refugees say that they did not know trust in their home country. Others say that it is a feeling you have in your heart when you look into someone’s eyes, something they could not do at home. Others say that trusting is not good because one will end up in trouble because it can be misused, or that trust is when you can tell any thing to someone, etc. All these are indications that trust for refugees carries the meaning of the past, present and future. The same applies in Rwanda. As for ex-prisoners, trust means feeling welcomed back to the community, having dignity and feeling like a human being again. For the widows it is regaining their dignity, having their voices heard in the community, earning respect etc. All these meanings that are given to trust reflect what life has been for the people concerned, the decisions they are making today and expectations they have for the future.

Sociotherapy in the Netherlands is done in a hospital setting, which may compel the clients to take on a sick identity in spite of the efforts to make the hospital as ordinary as possible. It can also be argued that having sociotherapy in a hospital plays into the hands of traditional power relations between patients and doctors. This may explain why in some cases clients feel that they can sway the power relation into their favor, something that may give another meaning to trust and also puts the sociotherapists in a dilemma.

For instance sociotherapists are not allowed to participate in any decision regarding asylum application because the asylum application and care for the asylum seeker’s health are seen as
strictly separated activities. It is the duty of the judicial system to assess the reliability of the refugee’s story, whereas the healthcare providers treat his/her psychological problem.

Through sociotherapy that clients learn more about the social, economic and political life of the Dutch society. Together with sociotherapists refugees learn the Dutch language, discuss how local politics work, how the local education system works and how one gets admitted to institutions such as education, health insurance, how to manage financial support from social services, etc. Sociotherapists deem this information essential to help refugees manage their lives more easily in a complex and individualistic Dutch society. This can be compared to what sociotherapists do in Rwanda by helping beneficiaries to create associations of income generating activities. The only difference is that in Rwanda outside group meetings sociotherapists continue to be what they were to beneficiaries during group meetings; advisors, counselor, friends, teacher etc. Here in the Netherlands all is said and done within hospital settings.

In conclusion, the completion of this work has been inspirational and insightful to me personally. In the light of my experiences in both countries and in spite of differences I alluded to earlier, sociotherapy is about doing and talking ordinarily as a way and means of getting out of extraordinary past experiences. It is through these ordinary experiences that take place in sociotherapy that trust is created and develops. In the case of refugees here in the Netherlands it is through sharing their stories, eating, cooking, walking, cycling and expecting good things from sociotherapists that they find the meaning of trust; hence trust for them is rediscovering an ordinary life.

Lastly, it may be difficult to identify elements from one context that can or cannot be applied to the other due to the differences I highlighted in this thesis about the Rwanda context and the Netherlands context. However, there is one element I found in both clinics that can be applied in Rwanda and could be helpful there. If sociotherapists in Rwanda could set a short moment either before or after each session of sociotherapy to discuss individual cases and if possible have an individual form that contained information they deem important, it would help the sociotherapists to monitor the dynamism in the group as well as individual progress in sociotherapy.
6. REFERENCES

Bhattacharya, R., Devinney T. M., & Pillutla M. M.

Bisharat, G. E.

Cieslik, A., & Jura, E.

Clark, C. C.

De Ruuk, N.
2002 Good Practice in Mental Health and Social Care for Refugees and Asylum Seeker. 1-58.

Doney, P. M., Cannon J. P., & Mullen M.

Dwyer, D. P., & Minnegal, M.

Edelson, M.

Fainzang, S.

Falcone, R., & Castelfranchi C.

Flores, F., & Solomon, R.C.

Foundation Centrum ‘45
2008 Sociotherapy in the clinic of Foundation Centrum ‘45.


Giddens, A.

Goold, S. D.

Gross C. S.

Haigh, R., Tucker, S.

Hall, A., M.


Hupcey, J., E., Penrod J., Morse M. J., & Mitcham C.

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Jackson, M.

Johnson, W. & Johnson P. F.

Kenard, D.

Koser K.

Kraetschmer, N., Sharpe, N., Urowitz, S., & Deber, R.

Lees, J., & Manning N., & Rawlings, B.

Lewicki, R.J., Mcallister. D., & Bies, R.

Lewicki, R. J., Tomlinson E. C., & Gillespie N.

Lewis, J.D., & Weigert, A.

Long, N.& Long A.

Maguire, S., Phillips, N. & Hardy, C.

Mayer, R. C., Davies J. H., & Schoorman, F.D.
Miller, K.E.

Miller K.E.

Miller K.E., & Rasco L. M.

Möllering, G.

Norton, K., & Bloom, S. I.

Ortner, B. S.

Rapoport, R. N.

Rousseau, D. M., Sitkin, S. B., Burt, R. S., & Camerer, C.

Sandstrom, S., Martin, D., D.& Fine, A., G. Symbols

Shacknove A. E.

Van Stokrom, R.

Weinstein, M. H., & Stover E.

Whiteley, S.

Wikipedia

Williams, M.

Zaman, S.
2005  Broken limbs, broken lives. Ethnography of a hospital ward in Bangladesh. Amsterdam, the Spinhuis Publishers.

http://dictionary.reference.com/browse/sociocentric
www.inkiko-gacaca.gov.rw