Complex Trauma: A Critical Analysis of the Rwandan Fight for Liberation

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Abstract

Post-genocide Rwanda illustrates the damaging effects of colonialism, systematic oppression, and the need for transnational trauma interventions for continental and African people in the Diaspora. This paper is rooted in a phenomenological understanding of Rwandan trauma and healing experiences, which focuses on examining healing narratives of those who were impacted by the 1994 genocide. Findings will highlight the gaps in Western bio-medical interventions, underline indigenous trauma experiences, and incorporate Liberation Psychology as a treatment foundation for Rwandan trauma survivors.

Keywords: Rwanda, Diaspora, Trauma, Liberation Psychology

Introduction

In the past 50 years, the majority of the world's violent political conflicts have taken place outside of the West (Miller, Omidian, & Quraishy, 2006). These areas maintain cosmologies, which can vary drastically from the worldview found within Western industrialized societies. In many cases, the contours of indigenous worldviews in continental and African Diaspora societies are directly connected to their experiences with colonialism and structural oppression (Vargas, 2005). Thus, African centered trauma interventions for continental and African people in the Diaspora must account for (a) traditional pre-colonial indigenous understandings and experiences, as well as (b) indigenous understandings and experiences of trauma related to colonization, structural oppression, and Ma'afa (the African holocaust).

This paper examines Rwanda's current struggle for liberation from the deleterious effects of international oppression. Appropriate trauma interventions must be grounded in the country's complex history as well as incorporate Rwandan constructs of healing. Rwanda, a nation the West seemingly affiliates only with the 1994 genocide, has a long history of colonial oppression dating back to the German (1893-1923) and Belgian rule (1923-1962). Notably, the Rwandan government "maintains that the unity of Rwandans was destroyed by first German and then Belgian colonialism" (Buckley-Zistel, 2009, p. 35). Hegemonic forces implemented a church-dominated socio-political system, which created a sharp division in status among Rwandans. Further, colonial rule exacerbated perceptions of ethnic differences, relegating the Hutu and Twa as inferior to the Tutsi ethnic minority (Kubai, 2007). Rwandans rejected this externally imposed hierarchy, and in a span of 100 days, approximately 800,000 to 1,000,000 Tutsi and non-compliant Hutu citizens were massacred by the Hutu extremists. Despite national reconciliation efforts, the effects of neo-colonial trauma pervade Rwandan communities to present date.

Limitations of Western Constructs of Traumatic Adjustment

Western professionals tend to conceptualize the post traumatic adjustment of Africans dispersed throughout the globe based on diagnoses rooted in a biomedical model rather than viewing traumatic presentation in light of historic and extant socio-political factors. There is still much to be learned in regards to the unique impacts that enslavement has had on African people. The study of slavery in Africa and throughout the Diaspora warrants increased attention and is, indeed, a global phenomenon (Larson, 1999). Pan-African narratives are vital to the understanding and dissemination of African trauma and healing experiences yet much of the trauma literature espouses from Western-funded bio-medical research.

Given the legacy of colonialism in Rwanda, as well as the colonial history surrounding the genocide, we have remained cautious in our examination of trauma interventions in Rwanda due to the tendency for them to be culturally biased towards Western constructs of health, illness, and healing. Additionally, the lack of public libraries in Rwanda makes it difficult for scientific research to be disseminated. Despite the existence of research ethics committees, it is surprising, then, to find that research has been done in Rwanda and published by foreigners, without Rwandan citizens necessarily having any knowledge about it (Levers et al., 2006). For this reason, it is understandable that we have been limited in our analysis by research that primarily has not been conducted by African people.

Prevalence rates for posttraumatic stress disorder (PTSD) fall between 15%-50% in countries with a history of war, including Rwanda eight years after the genocide (Pham, Weinstein, & Longman, 2004). An inflexible adherence to the language and constructs of Western psychology and psychiatry risks prioritizing psychiatric syndromes which Western practitioners are familiar with, such as posttraumatic stress disorder (PTSD), when other idioms of distress are in fact more relevant for the given culture.

Moreover, favoring Western diagnostic conceptualizations rather than honoring indigenous understandings of trauma further propels the forces of structural oppression, thus silencing African views in deference to Western models. The term *category fallacy* refers to the erroneous assumption that a diagnostic construct developed in one cultural setting is meaningful in a different cultural context (Kleinman, 1987). Drawing on the concept of *category fallacy* rather than relying on PTSD as a diagnostic label, this paper utilizes Rwanda as a case study in order to examine the particular ways distress is experienced, expressed, and understood within a subset of Pan-African culture. Further, Rwandan culture and trauma narratives will be examined in order to gain a more holistic picture of how health versus impairment in psychosocial functioning are defined locally and perhaps throughout the global Diaspora.

Limitations of Western Bio-Medical Trauma Models

There is little empirical literature investigating the multifaceted nature of indigenous approaches to healing, particularly African traditional healing methods. In Rwanda, it is unclear what aspects of indigenous healing practices the community experiences as most healing. The field of psychology has predominantly relied on Western-oriented trauma models, which further ostracizes African populations around the globe. Moreover, this investigation and intervention model has come to shape the way Western professionals conceptualize transnational posttraumatic adjustment (Kulkarni, Kushner, & Miller, 2006; van der Kolk, Pelcovitz, & Spinazzola, 2005).

The analysis of trauma can be a daunting task for numerous reasons. The subjectivity of trauma experiences is primarily studied via quantitative methods that often raise challenges in capturing the totality of the effects of complex trauma on individuals. In the article *Complex Trauma, Complex Reactions: Assessment and Treatment*, Courtois (2008) states that "complex trauma refers to a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts" (p. 86). Notably, the term *complex trauma* came into existence over the past decade when researchers began to find that some forms of trauma were much more complicated than others (p. 86). Courtois encourages researchers to expand their understanding of trauma to include all types of catastrophic events even acute and chronic illness that require ongoing and intensive (and often painful) medical interventions or a single catastrophic trauma (p. 86). This definition of complex trauma will lay the foundation for this phenomenological analysis because it acknowledges the diversity of trauma experiences and responses amongst individuals.

3

Rwandans have experienced centuries of oppression due to colonization and civil war. In Rwanda, the trauma was experienced as a group, therefore, adequate trauma interventions need to be collectivistic in nature and embrace the uniqueness of this small African country. This paper aims to highlight the gaps in the traditional bio-medical perspective of trauma interventions while simultaneously advocating for the use of African centered methods of healing for complex trauma reactions in Rwanda and throughout the Diaspora.

Research Questions

The primary goal of this paper is to increase the awareness and understanding of Rwandan traumatic reactions and use this understanding to develop transnational trauma intervention recommendations that embrace local idioms of distress as well as protective factors and collective expressions of resiliency represented within populations of the African Diaspora. Therefore, the specific research questions are as follows:

- What are the phenomenological themes of Rwandan indigenous experiences, understandings, and expressions of trauma and healing processes?

- How are Western perspectives of mental illness inconsistent with the Rwandan trauma experience?

- How may the Rwandan ideology promote a more global understanding of traumatology?

The research philosophy chosen for this paper is a phenomenological one that will allow the researchers to descriptively study the individual and collective experiences of Rwandans who survived the 1994 genocide. An in-depth meta-analysis was performed in order to comprehensively examine the phenomenological experiences of Rwandans. Specific attention was placed on existing intervention programs in order to better assess their limitations. Therefore, this paper has two primary components: a comprehensive meta-analysis of pre-existing literature and recommendations for future trauma interventions with African people. The recommended trauma interventions focused on the following main components:

- Utilization of the phenomenological information about Rwandan's trauma experiences post-genocide.

- Enhancement of the resiliency and strengths of Rwandans by using their traditional methods of healing as the principle foundation for trauma intervention.

4

This investigation aims to illuminate the uniqueness of neocolonial trauma and the sacredness of traumatic reactions amongst Rwandans in order to support their liberation process. In order to fully examine the gaps in Western healing constructs when applied to African communities, one must examine both the strengths and deficits of such models. The next section is devoted to objectively examining the current trauma interventions available to Rwandans.

International Trauma Intervention Initiatives

The Rwanda holocaust has been extremely difficult for survivors to overcome. Not only has the Rwandan language had to make room for the devastation the genocide left behind, but the survivors are now faced with the responsibility to heal the wounds of a bleeding nation. A new word entered the Rwandan vocabulary in 1994, *ihahamuka*, which refers to a variety of psychological manifestations thought to originate from the genocide. The word comes from bringing together two words: *hana* (lungs, respiration) and *muka* (without). Because 91 percent of survivors did not have a chance to bury their relatives or perform mourning ceremonies, and nearly as many had not yet seen the remains of loved ones, the bereavement process has not been allowed to take its natural course (Brahm, 2004).

Given the magnitude of the trauma experienced by survivors of the genocide, relatively little attention has been paid to the problem of psycho-social healing. According to the Joint Evaluation of Emergency Assistance to Rwanda (Dabelstein, 1996) donor efforts have concentrated primarily on trauma counseling for children. In addition, some organizations, mostly religious in nature, have attempted to confront the ethnic animosity directly through reconciliation workshops and community healing initiatives and indirectly within the context of their other programs. "Missed opportunities in exploring indigenous concepts of mental health and methods of healing conceivably stem from initial lack of understanding of Rwandan society, psyche and culture, and the absence of adequate language skills, so vital to confidential communication" (Dabelstein, 1996).

Most of the training programs in trauma counseling are directed at individuals working with the 4 million children under the age of 18, whom UNICEF (United Nations Children's Fund) has identified as being "of concern." Reportedly, both UNICEF and several NGOs (non-governmental organizations) offer workshops for primary care-givers on the nature, symptoms and causes of trauma and on various techniques to promote healing (Staub, 2006; Smith, 1998). The intended audience includes foster parents, social workers, and staff of unaccompanied children centers, teachers, health-care workers, religious educators and members of widows' associations. Notably, more attention is being paid to indigenous approaches to healing, which is central to Rwandan culture (Grey & Manning, 2007; Kubai, 2007). While many forms of counseling are based on Western psycho-therapeutic models, others advocate more indigenous approaches to the healing process; some training focuses specifically on trauma recovery, while other forms consider the wider psycho-social environment including school, peer groups, family and the social milieu (Bolton, 2000; Sedon, 2003).

Several NGOs have attempted to bring together individuals through workshops and dialogues that address the conflicts within Rwandan society. For instance, these projects have involved outreach to different segments of the Rwandan population - orphans and child-headed households, widows, genocide survivors, World Vision International staff members and those imprisoned for crimes committed during the genocide (Sedon, 2003). Health Promotion (HPR) interventions have included counseling workshops and skills training, radio shows, public drama and sporting events promoting reconciliation, and training of school counselors. World Vision International has run workshops in 14 of its Area Development Programs (ADP) (Sedon, 2003). Religious organizations have held similar in-house seminars in efforts to heal the deep divide that splits the churches and crosses ecumenical lines (Kubai, 2007). Workshops generally included speakers offering various points of view on the healing process, open discussion, small group interaction and debate over specific issues. However, contention surrounding the Christian church's role in the genocide serves to abrogate its traditional conciliatory function (Kubai, 2007).

Attempting to comprehend the deep wounds within Rwandan society and trying to find ways to assist in the healing process is a formidable undertaking (Staub, 2004; Umutesi, 2006). It is extremely difficult for the international community to help in the early realization of community integration when lasting societal reconciliation appears remote. The lack of justice for the surviving victims of genocide and the continual nationwide fear of renewed violence pose seemingly insurmountable obstacles to peace at this time. In addition, there is evidence of rising anger and mistrust among Rwandans of each other, specific organizations and the international community in general (Thurman, Snider, Boris, Kalisa, Nyirazinyoye, & Brown, 2008; Buckley-Zistel, 2006). Some of this stems from a sense that the international community abandoned Rwanda during the time of most need (Grey & Manning, 2007). Fourteen years after the fact, the Rwandan genocide continues to play itself out on the soil of the Democratic Republic of the Congo. There, rebel forces ostensibly acting to protect Congo's endangered Tutsi minority, have taken control of much of an eastern province and are en route to the provincial capital of Goma. The current conflict in the Democratic Republic of the Congo is a dramatic reminder of the urgency of dealing once and for all with the unfinished story of the Rwandan holocaust (Umetsi, 2006).

In 2000, World Vision International, the United States Agency for International development, Johns Hopkins University, and Tulane University conducted a cross-cultural assessment of trauma-related mental illness in Rwanda (Bolton & Ndogoni, 2000). The primary focus of this project entailed creating an instrument adaptation and validation process which NGOs and other organizations could use globally to quantitatively assess the mental health burden of trauma at the population level. The developing instrument and procedure were utilized to assess the mental health burden of trauma in Rwanda. More specifically, this part of the international study sought to (a) ascertain if Rwandans experienced Depression as a result of trauma and (b) identify names and symptoms of indigenous "Depression-like illness" (Bolton & Ndogoni, 2000). Notably, this study was conducted only with adult samples, setting this study apart from most international intervention.

6

Findings from this ethnographic study purported that "local people experience all the DSM (*Diagnostic and Statistical Manual of Mental Disorders*) diagnostic symptoms of Depression as a result of the 1994 genocide" (Bolton & Ndogoni, 2000, p.9). However, this study also identified *Agahinda gakabije* ("severe grief") as the closest indigenous expression of Depression. Bolton and Ndogoni (2000) realized that local Rwandans "do not organize symptoms into an entity similar to Depression that we could use for direct comparison" (p.9). Thus, it should be noted that while Rwandans may meet the criteria for Western diagnoses, alternate symptoms are likely to be more salient for persons of this culture.

Enactments of Healing Initiatives

The work with community-level social agents-teachers, health workers, community and religious leaders-coordinated on the district level by trauma advisors and health centers, was promoted as the most effective and sustainable way to reach beneficiaries. It was suggested that a community-oriented approach should be implemented through the primary health care system to ensure better effectiveness of the interventions in the future (Chauvin & Comlavi, 2005).

Large-group approaches to healing include testimonials and commemoration. They offer the opportunity both for engagement with experience and reconnection. It seems important for such commemorations to focus not only on the pain and suffering, which can make wounds persist and make the past into a "chosen trauma" (Volkan, 1997), but also on hope, the possibilities of a better future.

As to traditional medicine and mental health care, researchers reported that before 1994, traditional healers and the more Western medical system were equally used by the population. The traditional healers used to have a holistic approach. Unfortunately, few survived the genocide and they now concentrate more on herbalist skills (Chauvin & Comlavi, 2005).

Painful experiences facilitate healing, about 50% of the population, and thus 50% of the people who were trained would later work with, could not write. Therefore, interventions should keep this critical finding in mind when developing programs that require literacy (Staub, 2006).

While the international community has attempted to respond to the aftermath of the 1994 Rwandan genocide, few interventions have sought to reach the core sources of the violence (Christie, Tint, Wagner, & Winter, 2008; Logan, 2006). Reconciliation efforts have been initiated between the ethnic Hutu and Tutsi, yet the culpability of developed nations often remains unrecognized. For Rwanda and other continental and African Diaspora populations to achieve true liberation, the international arena must admit accountability for the effects of colonization and imposed socio-political hierarchies and borders (Vargas, 2005; Logan, 2006; Watkins & Shulman, 2008).

Equally imperative to healing from the African holocaust, international trauma interventions must give voice to Rwandans experiences, understandings, and expressions of their own trauma or distress. To be liberating, or truly healing, trauma interventions for Rwandans must be tailored to their indigenous cosmology rather than exported from Western nations. In order to promote a more liberating framework for trauma intervention, the next section of this paper focuses on the particular ways local Rwandans responded to and made sense of the 1994 genocide.

Phenomenological Themes of Healing

Experiences of Distress

Survivors of the Rwandan genocide have reported feeling diminished and vulnerable as a result of the violence they experienced. They have reported perceiving the world, especially members of groups outside of their own, as dangerous (Staub, 2004). While feelings of mistrust are considered common in Western post-trauma conceptualizations, perceiving 'the other' as dangerous in the aftermath of genocide rooted in ethnic division bears heavier consequences. This mistrust, fear, and aversion to another along lines of ethnic differences catalyzes the potential for multigenerational transmission of trauma and runs counter to national reconciliation efforts (Logan, 2006; Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009). Feelings of insecurity of self and insecurity towards the other will have to be worked through carefully and extensively in the healing process.

In addition to feelings of vulnerability and ethnic division, current stressors, including living in poverty, having to care for one's siblings, and witnessing *Gacaca* (a participatory community court traditionally used for dispute resolution) processes often trigger flashbacks to their trauma experiences (Buckley-Zistel, 2006; Brouneus, 2008; Kaplan, 2006). While symptoms of re-experiencing traumatic memories or events are consistent with the DSM-IV's (*Diagnostic and Statistical Manual of Mental Disorders*, 4th edition) diagnostic criteria for posttraumatic stress disorder, in Rwanda, re-experiencing the trauma of the 1994 genocide is likely due to the close proximity that perpetrator and survivors are forced to live and the high level of daily interaction between victim and perpetrator. For example, the *Gacaca,* or the participatory community court process traditionally used for dispute resolution in Rwanda, has been formalized by the government and appropriated for use as a tribunal process for genocide criminal suspects (Buckley-Zistel, 2006; Brouneus, 2008; Kaplan, 2006).

The *Gacaca* is conducted in locales throughout Rwanda, and genocide offenders are held accountable for their crimes. This process is integral to processing Rwandan trauma as reconciliation in Rwanda requires listening to the nation's history (Buckley-Zistel, 2009). Although justice is important and can contribute to healing, this process often causes victims, perpetrators and witnesses of the Rwandan genocide to relive their trauma experiences.

Western professionals must exercise caution when interpreting the anxiety and traumatic memories which surface during participation in the *Gacaca* process as "re-experiencing" as described in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition text revision (DSM-IV-TR). Viewing Rwandans' re-experiencing as a psychiatric symptom of posttraumatic stress disorder instead of a component of community reconciliation is a clear example of category fallacy; the focus of trauma interventions in Rwanda must necessarily shift away from diagnostic constructs developed from research with Western populations and instead center on providing support for people who are confronting painful memories, including victims, perpetrators, and bystanders (Cohen et al, 2005; Khristie et al, 2008).

Understandings of Distress

While remembering the genocide seemed to be universally important to Rwandans, the memory of the genocide did not appear to be a unifying factor (Buckley-Zistel, 2006; Chauvin, Mugaju, & Comlavi, 2005; Mukamana & Brysiewicz, 2008). In one study, despite that fact that none of the interviewees disagreed with the statement that "the genocide was committed against the Tutsi," it was found that a large quantity of the Hutu population also considered themselves to be victims of the genocide. Hutu experiences of victimization included persecution through war, refugee camps, and post-genocidal revenge killings (Buckley-Zistel, 2006).

In line with this blurred ability to differentiate victim from perpetrator, Rwanda's genocide memorials are a source of much controversy over memory. Buckley-Zistel (2006) found that Rwandan interviewees' responses indicated a strong and clear divide on how Rwanda's history pertaining to the 1994 genocide should be recounted. In essence, Rwandan experiences and conceptualization of the genocide depended largely on their ethnicity. Current daily experiences in Rwanda continue to be reliant on ethnic division (Buckley-Zistel, 2006; Kaplan, 2006; Mukamana & Brysiewicz, 2008). Thus, despite the collective memory of the genocide as a horrific event, the anger and resentment deriving from post-conflict circumstances affect both personal and community relations, perpetuating the divisions between Hutu and Tutsi. In order for trauma interventions to be effective then, dichotic understandings of the genocide will have to be bridged.

Expressions of Distress

Mukamana and Brysiewicz (2008) found that Rwandan women who survived the genocide explained their experiences of trauma through themes unique to this population. Unique expressions of their distress include, but are not limited to: violation by perceived inferiors, loss of dignity and respect, loss of identity, social isolation, and loss of hope for the future.

For example, during the Rwandan genocide, a myth existed idealizing ethnically Tutsi women as 'sexually sweeter' than ethnic Hutu women. Women participants in Mukamma and Brysiewicz's study gave testimony on how they felt after being raped by men of inferior societal status. They reported that for the militias, rape was a form of revenge against the women they otherwise would not have access to and therefore also an act of revenge against entire communities.

Women's testimony of loss of identity and social isolation related to gender roles dating back to pre-genocide Rwanda. Prior to the 1994 genocide, Rwandan women were battling not only the national structural problems, including food shortages and economic constraints, but also systemic gender-based discrimination. Rwandan males controlled family property as well as any accessible resources. Women were considered to be dependent on their male counterparts; Rwandan women were expected to be managed and protected by their fathers, husbands and male children (El-Bushra & Mukarubuga, 1995; Human Rights Watch, 1996). Therefore, as a result of societal conceptions of women's dependence, female gender roles traditionally centered on the position of a woman in relation to her family. Therefore, Rwandan girls and women were conceptualized within the context of daughters, wives, and mothers (Human Rights Watch, 1996; Chakravarty, 2007).

With the sexual violence embedded in the 1994 genocide, many Rwandan adolescent girls lost their virginity through rape. Loss of identity and social isolation experienced by Rwandan females in the aftermath of the genocide often related directly to the loss of virginity. By losing their virginity through rape, Rwandan females faced the social issue of not belonging to the in-group of women nor the in-group of girls (Cohen, d'Adensky, & Anastos, 2005; Chakravarty, 2007; Mukamma, et. al, 2008). Further, Rwandan women impregnated through rape faced the additive trauma of raising children born of rape. For some women, loving their children came naturally, however, these women often had to fight with relatives who could not understand loving an *Interhamwe's* (a member of a terrorist Hutu paramilitary organization) child. For other women, caring for a child born of rape was impossible, leading to the neglect or torture of hundreds of newborn or unborn children (Mukamana, et. al., 2008).

There is overwhelming evidence that the ethnic cleansing left devastating effects on the entire Rwandan population—survivor and perpetrator (Buckley-Zistel, 2006; Buckley Zistel, 2009; Hollifield, et. al., 2002; Kaplan, 2006; Mukamana, et. al., 2008). The collective traumatic experience permeating Rwandan culture gives evidence to the deep need for group healing within the entire African Diaspora. Socio-cultural subjugation is a plague within many African Diaspora communities and until indigenous healing constructs are utilized the plague will only continue.

Cultures, such as Rwanda, have utilized traditional healers for centuries; however the use of socio-spiritual trauma interventions is often overlooked by the Western bio-medical model of health verse healing. The following table summarizes the principle phenomenological experiences of Rwandans following the 1994 genocide. This table highlights the importance of incorporating historical effects of colonization, indigenous modes of healing and specific community strengths into complex trauma interventions.

11

Phenomenological Themes of Rwandan Trauma		
Experiences	**Understandings**	**Expressions**
1. Feeling diminished and vulnerable 2. Loss of a sense of community 3. Child-led households	1. Retraumatization via community peace-building efforts (e.g. Gacaca) 2. Contrasting perspectives consistent with ethnicity 3. Existing transgenerational trauma stemming from pre-1994 acts of violence 4. Blurring lines between victim and perpetrator	1. Loss of identity 2. Social isolation 3. Loss of hope for the future (e.g., HIV/AIDS) 4. Violation by perceived inferiors 5. Internal dilemma of mothering 'rape babies'
Narrative Example: "When we got there, they asked us if we knew what ethnic group we belonged to. One of them told us to show them our hands because they could tell from the palm of our hands. He said that Hutu do not have the middle line in the hands, while Tutsi have the middle line straight. As I bent to open my hands, one of them grabbed my sister's child… They turned to me, took the baby from my back… grabbed me and threw me in burning coffee husks and I got burned everywhere while they were just laughing. After some time, they took me out of the fire and threw me in a pond that was nearby thinking I would drown. It was good that the baby had been taken from me—I would not have been able to carry him as I had been burned all over. I cried loudly and one of them said, 'Why don't we finish that fool and stop having him making alarm for us?'" *-Frederic, 9 years-old during the Rwanda genocide, speaking of an incident at a roadblock* (Kaplan, 2006).	Narrative Example: One Hutu interviewee, insisted that he too should be labeled a "survivor" of the genocide, a term usually reserved for Tutsi survivors, stated, "It is important not to forget the past so that we can prevent the future. But the bad was not only the genocide but also the Hutu who died in the Democratic Republic of Congo of diseases, and also those who were killed in revenge when they came back. Nobody has won this war; everybody has lost at least one family member." *-Anonymous* (Buckley-Zistel, 2006).	Narrative Examples: "I am wondering who will bring her up after my death. My aunt who survived the genocide doesn't like my child as I do. She said that it will be an eternal torture to bring up an Interahamwe's child as she will remind her of how the Interahamwe have decimated our family." *-Anonymous Rape Survivor* (Mukamana & Brysiewicz, 2008) "With the rape I lost my identity as a girl. When a friend of mine invites me to a party, I can't go…I don't know if when I go I have to be with the girls or with the women. I am not a girl and I am not a woman." *-Anonymous Rape Survivor* (Mukamana & Brysiewicz, 2008)

Healing Narratives

Those trained in listening to and uncovering the themes in personal narratives are particularly useful in liberatory research because they are able to critically analyze personal stories within the context in which they were offered (Prillitensky & Nelson, 2002). Liberatory research has the potential to help participants "dis-identify with destructive and disempowering thoughts, feelings, and assumptions" (Watkins & Shulman, p. 297). The following section highlights one specific theory in psychology that values personal narratives of resistance and healing, while simultaneously empowering individuals to find liberation.

Liberation Psychology: A Response to Colonialism

Liberation is not individualistic, it is not isolated to a specific type of suffering; it is a communal, environmental, political and psychological freedom that is fought by love. Although "Liberation psychology" was hallmarked by the Salvadoran Jesuit priest and psychologist, Ignacio Martín-Baró, it still holds increasing prevalence for communities in the Diaspora (Watkins & Shulman, 2008, p. 23).

Watkins & Shulman (2008) describe Liberation psychology as involving "transformation of fatalism into critical consciousness, an awakening of agency and the power to perform our roles differently, and a quickening of imaginations of desire" (p. 25). A psychology that encompasses these traits cannot ignore the psychological wounding caused by war, racism, poverty, and violence. Furthermore, Liberation psychology is unique because it supports "historical memory and critical reflection" (Watkins & Shulman, p. 25); thus this mode of psychology facilitates an understanding of the connection between colonialism and trauma within African cultures. Buckley-Zistel (2009) states that "authorities invent traditions—and their seeming continuity with the past—in order to maintain authority, forge social cohesion and create a common culture" (p. 32). With this in mind, this work attempts to participate in the international dialogue of remembering and healing by examining the phenomenological experiences of Rwandans struggling with complex trauma reactions.

Psychological problems are not individual problems but instead are representative of an individual's relationship with history and society (Larson, 1999; Grey & Manning, 2007). Specifically, we understand that the field of psychology must "illuminate the links between an individual's psychological suffering and the social, economic and political contexts in which he or she lives" (Watkins & Shulman, 2008, p. 26). Larson (1999) outlines the cultural significance of intra-continental displacements of Africans as a result of the slave trade. In order to fully understand the traumatic impact experienced throughout the Diaspora "narratives are key to understanding the meaning and texture of African experiences of enslavement and identity formation" (Larson, 1999, p. 340). Shared trauma and bondage continue to forge a sense of community between African people and their descendents in the Americas (Larson, 1999).

However, despite the commonality of experiences, such as enslavement, forced migration, master hood, and economic-cultural transformation, it is vital to "not generalize from specific African experiences, modes of popular memory, or types of identity formation to the whole African Diaspora" (Larson, p. 360).

Liberation psychology asserts that oppressed citizens "learn through a communal process of discovering perspectives, imagining different strategies, trying them out and then evaluating failures and successes" (Watkins & Shulman, 2007, p. 27). This assertion is particularly critical to the future of psychology as it relates to trauma interventions for African people because it calls for dialogue—a dialogue about painful human experiences that is frequently missing in psychological research. This very dialogue is critical to the treatment of trauma because it calls all people involved in the healing process to be transformed and humanized through participation in critical dialogue and creative imaginations about alternatives (Watkins & Shulman, 2007; Vargas, 2005; Freire, 1970).

The *Gacaca*, or current restorative justice system in Rwanda, has the potential to catalyze Rwandan healing and liberation on the community level by promulgating this necessary communal conversation (Brouneus, 2008; Buckley_Zistel, 2006). These participatory community courts should be used not just as a venue for encounters between ethnic groups and the profession of accountability, but also for the transformation of individuals, relationships, and community structures. Conversations should be seen as conscious-raising with the intent for mobilizing collective action towards resistance, reconciliation and healing. Notably, international governments must also engage in similar dialogue with Rwandans; for a truly liberatory process to occur, also, the international governments which contributed to the root causes of the genocide must take responsibility for perpetuating hegemony and structural oppression (Kubai, 2007).

Moreover, Liberation psychology, coupled with African centered perspectives, as a foundation for trauma interventions comes with multiple benefits. Current research on trauma indicates that psychological distress is not only an individual matter but "it is linked to normalized power structures, gender relations, and ongoing cultural trauma" (Watkins & Shulman, p. 14). There are many issues that Rwandans face that are directly connected to historical memory and amnesia (Buckley-Zistel, 2009). Additionally, the refusal of international discourse concerning slavery, enslavement and genocide and the dictatorships and terror throughout the continent and within the African Diaspora further exacerbates the complex trauma reactions of these individuals. In order to fully conceptualize the impact that these issues have on the human psyche of Rwandans there needs to be a public setting of accounts that exceeds the capacities of the individual clinical encounter (Watkins & Shulman, p. 14).

Also, the loss of community is another factor that Rwandans must deal with. During the 1994 genocide the battlegrounds were the cities, villages and towns that these individuals live in. Thus, via a Liberation psychology perspective, psychologists can comprehensively treat an individual's traumatic experiences while simultaneously making links with the individual's historical and environmental conditions. This is important because, the current Western-biomedical model for treating trauma falls short of considering the Rwandan trauma in light of their historical and environmental experiences.

In summary, the benefit of utilizing Liberation psychology as the framework for African centered trauma intervention is that it does not analyze the individual's symptoms independently from their environment, culture, society and political circumstances (Watkins & Shulman, 2007). Hence, the implications that Liberation psychology has for trauma interventions, for any age group, are vast and have the potential to revitalize and empower entire African communities. It is indisputable that colonialism in Rwanda had a devastating effect on the social, political and economic composition of the nation (Buckley-Zistel, 2009). The historical narratives of Rwandans include clear evidence of the traumatic influences of colonialism; therefore, a trauma intervention model that incorporates African psychology, liberation, and healing narratives is critical for African people in Africa and African descendents throughout the globe, given their unique shared history of resistance and healing.

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