After the Genocide in Rwanda: Humanistic Perspectives on Social Processes of Post-Conflict Posttraumatic Growth

Stephen Joseph

University of Nottingham

Correspondence should be addressed to Stephen Joseph, PhD, Professor, School of Education, University of Nottingham, Nottingham, United Kingdom NG8 1BB.

E-mail: Stephen.joseph@nottingham.ac.uk

The aim was to contribute to an understanding of social processes of post-conflict healing, reconciliation and development, by reflecting on what lessons might be taken from posttraumatic growth research to inform trauma practitioners and researchers in Rwanda. Following a theoretical discussion on the implicit assumptions, limitations and dangers of imposing ideas from Western psychology, it is concluded that we might be best advised to turn to humanistic psychology with its person-centered stance of recognizing that it is the people themselves who will be their own best experts.

Keywords: psychological trauma, posttraumatic stress, posttraumatic growth, person-centered, medical model

After the Genocide in Rwanda: Humanistic Perspectives on Social Processes of Post-Conflict Posttraumatic Growth

It is almost twenty-five years since the genocide against the Tutsi in Rwanda in 1994, an event that led to shattered lives, displaced people, and for a time, a broken society. Rwanda has since prospered as a nation, but for those who lived through the genocide their memories remain and their losses are still real.

This paper arose as a result of an Arts and Humanities Research Council (AHRC)[1] grant to study testimonies of survivors and perpetrators of the 1994 genocide in Rwanda – the Rwandan Stories of Change research project. The final aim of the project is to contribute to broader processes of post-conflict healing, reconciliation and development. While it might be expected that analyses of the testimonies would show the horror and the tragedy, the distress and suffering, and the complications of survivors and perpetrators learning to live alongside each other again, what was surprising was that there were also stories of posttraumatic growth (PTG). PTG is a concept that recognizes that in the struggle to overcome adversity, people often identify positive psychological changes. As such, this paper sets out to begin to address the final aim of the project by considering the implications of the observation of PTG for the broader processes of post-conflict healing, reconciliation and development in Rwanda.

First, I will describe the context of the genocide in Rwanda and the psychological aftermath. Second, I will provide a theoretical discussion on the implicit epistemological assumptions underpinning the psychology of trauma, concluding that we might be best advised to turn to humanistic psychology with its person-centered stance of recognizing that it is the people themselves who are their own best experts. Third, I will show how a person-

[1] AHRC Reference: AH/M004155/2: research team: Laura Blackie, University of Nottingham; Hannah Grayson, University of St Andrews; Nicki Hitchcott, University of St Andrews; and Stephen Joseph, University of Nottingham.

centered understanding of PTG contributes to the broader processes of post-conflict healing, reconciliation and development. Finally, I will reflect on the new lines of research and practice that arise from theory.

THE GENOCIDE IN RWANDA AND ITS PSYCHOLOGICAL AFTERMATH

The causes of the genocide are thought to be rooted in colonial rule. In 1884, Germany colonized Rwanda as part of German East Africa, followed by Belgium, which invaded in 1916. The arrival of the Germans and Belgians exacerbated tensions between the two main groups, the Hutu and the Tutsi, because the Tutsi minority were given social and political power. Following the 1959-1961 revolt over colonial rule the new government was pro-Hutu. Subsequently, thousands of Tutsi were killed and thousands more fled as the Hutu-led party sought to establish their power-base. Preceding the 1994 genocide, the Tutsi-formed political and military party, the Rwandan Patriotic Front (RPF), invaded from Uganda in 1990 leading to civil war. The invasion was used by Hutu extremists to promote propaganda against the Tutsi.

The massacres began after President Habyarimana's plane was shot down on 6 April 1994, with Hutu extremists blaming the RPF, although the planning of the genocide against the Tutsi and training of Hutu-militia were already underway. In 100 days between April and July 1994 it is estimated that up to 1 million people were brutally murdered using machetes and agricultural tools as well as conventional weapons of war. This was approximately 11% of the total population but nearly 75% of the Tutsi population (Magnarella, 2002). Hundreds of thousands of people took part in the brutal killings, often of their neighbors. Subsequently, some perpetrators have spoken of how the Rwandan authorities led them to believe that the Tutsi targets were a threat to the country and they saw their actions as an act of duty

(Hatzfeld, 2006). Others may have been motivated by gain from taking their neighbors' property. The genocide ended when the RPF captured Kigali in July 1994.

Lives were left devastated. Many lost their families and their homes. Many women had been raped and contracted HIV. The normal structures of society were broken; many of those who were previously in a position to help people were themselves killed, leaving a helping vacuum, and calls for the involvement of the international community (Kumar et al., 1996). Twenty years on, there has been much progress in rebuilding civil society and the country has flourished economically, but psychological consequences remain. In particular, posttraumatic stress disorder (PTSD) has been much discussed.

Posttraumatic stress disorder (PTSD)

PTSD was first introduced in 1980 by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) for Mental Disorders, now in its fifth edition (American Psychiatric Association, 2013). The development of the concept of PTSD was in large part a response by American psychiatry to the psychological suffering experienced by thousands of veterans returning from the Vietnam war. PTSD is a debilitating condition consisting of problems of intrusive memories, problems of avoidance, negative cognitions and disturbances in mood, and problems of arousal. PTSD affects the person's ability to function in their social and occupational lives.

Prior to the 1994 genocide the concept of PTSD was not much discussed in Rwanda, but received attention subsequently as a way to understand the psychological consequences. Community surveys in Rwanda following the genocide have reported prevalence of 25% at 8 years (Pham et al., 2004), and 26% at 14 years (Munyandamutsa et al., 2012). Rates may be higher in perpetrators than survivors (Schaal et al., 2012). Not surprisingly, there has been

much interest in how to plan interventions, and recognition of the need to build capacity for appropriate mental health counselling services in Rwanda (Levers et al., 2006).

Posttraumatic growth (PTG)

While the concept of PTSD has been widely applied to understanding the psychological aftermath, a newer line of enquiry over the past few years has been to explore the possibility of posttraumatic growth (PTG).

The term PTG was first coined in the 1990s to refer to the positive psychological changes an individual can experience following a traumatic life experience (Tedeschi & Calhoun, 1996). Unlike the concept of resilience, which describes how a person is able to return rapidly to their prior state of functioning following trauma, PTG describes how trauma can be a springboard to more fully functioning psychological states. Subsequently the term PTG has served as an umbrella for a range of research concerned with finding benefits, meaning making, and growth following adversity. Typically, there are positive changes in how a person perceives themselves, changes in their relationships, and changes in worldviews (Joseph, 2011).

Many studies have been conducted in the West over the past two decades following a wide range of events, including violence (Tedeschi, 1999), with estimates suggesting that typically 30-70% of people will experience some degree of PTG (Linley & Joseph, 2004). PTG has been shown to be related to increased well-being (Linley & Joseph, 2004) and altruism (Staub & Vollhardt, 2008), thus conferring benefits both on the individual themselves and by their actions on others.

While the concept of PTG originated in Western psychology it has since been subject to empirical investigation across different cultures. However, the application of PTG to other cultures remains in its infancy, particularly in the context of Rwanda. Weiss and Berger's

(2010) edited book on PTG and culturally competent practice contains chapters by researchers from many countries across the world, but the context of Rwanda was noticeable by its absence, although subsequently there has been interest (Arnold, 2011).

In our work at the Rwandan Stories of Change research project at the University of Nottingham in England and the University of St Andrews in Scotland, in collaboration with the Aegis Trust[2] and the Genocide Archive of Rwanda in Kigali, we have pioneered qualitative analysis of transcripts from survivors; first with Nicki Hitchcott's doctoral student Caroline Williamson who has gone on to publish her results on women's testimonies (Williamson, 2014; 2016), then building on this preliminary work we were able to obtain the AHRC grant to conduct further more in-depth analyses of testimonies and to extend the corpus to include other groups, particularly men and perpetrators of genocide.

Our narrative approach developed out of the humanities tradition of examining textual material but has since become a cornerstone of our research into PTG in Rwanda. In our first published study of testimonies, Blackie, Jayawickreme, Hitchcott, and Joseph (2017) conducted a thematic analysis based on 32 previously published oral testimonies retrieved from the Genocide Archive Rwanda collected during 2004-2011. We distinguished adaptive ways in which survivors have handled their new post-genocide lives - such as hope for a better future and a determination to make the best of life - from the themes of growth, namely empathy, wisdom, and forgiveness, qualities that represent positive changes that helped to cultivate a strong sense of commitment and social responsibility that extended to the genocide perpetrators. Our subsequent and more substantial work as part of this project (Grayson, Hitchcott, Joseph, Blackie, in preparation) has gathered more previously unpublished testimonies from individuals who lived through the genocide. Together these

[2] – Aegis is an international NGO working to prevent genocide through educational and research programs. It established the Genocide Archive of Rwanda in Kigali as a repository for information relating to the 1994 genocide.

studies do not simply paint a picture of lives left destroyed and damaged, but provides a collection of testimonies to focus specifically on positive change in Rwandan storytellers themselves, both the stories of survivors, but those of perpetrators, unity and reconciliation groups, and rescuers, as well.

In summary, there are high rates of PTSD in Rwanda and there is a need to address the problem of psychological distress in the population. But there is also initial evidence of PTG. The concept of PTG seems to offer a new and helpful way of thinking because it recognizes that after genocide, people cannot be expected to return to the life that they had before, but that there is an ongoing process of moving into the future in awareness of the social destruction and individual losses (Grayson, 2017). However, there is much criticism of researchers applying concepts derived in the west to other cultures (Summerfield, 1999). Such criticisms are widely applied to PTSD, but we must not assume that PTG because of its forward looking stance is immune to criticism. As such, the objective of the next section is to consider the limitations and challenges when ideas from the psychology of trauma developed in the West are imposed on other cultures, in this case Rwanda.

THEORIES OF TRAUMA, ASSUMPTIONS, LIMITATIONS, AND APPLICATION

Concepts in psychology are always built on epistemological assumptions. Thus, while it is entirely appropriate to consider the devastating effects of genocide on individuals, how we do this inevitably reflects our ways of understanding the world. As already discussed, the concept of PTSD has been widely applied as a way to describe the psychological suffering in Rwanda and to generate ideas on how to help those affected, but it represents a Western way of thinking that is not necessarily helpful to the challenges of reconciliation and development.

Epistemologically, the concept of PTSD represents a way of understanding experience from the medical model. Many scholars, from Szasz (1961) to more contemporary writers such as Maddux and Lopez (2015), and Sanders (2017) have voiced their criticisms of the assumption that human distress is an illness, arguing that illness is only a *metaphor* for distress, rather than a *fact.* However, the medical model remains the dominant ideology of distress, in which the notions of a broken brain or biochemical imbalance underpins distress. It is not necessary to reiterate these ideas further here, except in three respects: how the medical model focuses on characteristics within the person, seeks to provide expert based interventions, and is concerned only with deficits (Joseph, 2017).

The first assumption of the medical model is that problems are within the person. In the original 1980 DSM definition of PTSD, the stressor was defined narrowly as one that "would evoke significant symptoms of distress in most people". As such, only traumatic events that caused distress in almost all who experienced them were considered as fulfilling the diagnostic criteria. PTSD was indeed different and served a function that was helpful socially and politically in recognizing the mental health consequences in, for example, Vietnam veterans and Holocaust survivors. Seen this way, PTSD is unusual in the psychiatric literature in having a clearly defined external cause, which at first glance would seem to set it outside the criticism that befalls psychiatric diagnosis more generally of pathologizing and individualizing people's experiences. However, I will argue below that this is not the case.

Since 1980, the narrow definition of what constitutes a traumatic event has broadened beyond its original focus to include events which may lead to PTSD in some but not others. This "conceptual bracket creep" (McNally, 2010) is problematic, because in widening the definition in this way, personality and individual difference factors play a greater role. When everyone is affected, it implies that the event is all important. But if only one person out of ten develops PTSD, the question is what makes that person different?

As a result, research in PTSD has increasingly focused on the biological markers, personality factors, and individual differences, that make for vulnerability. This may be entirely appropriate to the needs of clinicians who are working with patients diagnosed with PTSD, but it inadvertently serves to medicalize the concept of PTSD in the same way as other psychiatric disorders, such that problems are seen as internal to the person.

The second assumption underpinning the use of the medical model is that there are specific treatments required for specific problems, thus diagnosis or formulation is essential in order to identify the exact nature of the problem in order to prescribe or provide the correct treatment. As such, working with this assumption it is the practitioner who knows what is best for the patient and what techniques are most suited for their treatment. This thinking very much applies to PTSD. However, it is a contested assumption by humanistic psychologists who say that if psychological problems are not an illness, such thinking simply may not apply (Bozarth & Motomasa, 2017).

Third, the medical model is concerned only with the alleviation of distress and dysfunction, and does not pay attention to the potential of human beings, a criticism of humanistic psychologists, and more recently positive psychologists (Maddux & Lopez, 2015).

Thus, importing the concept of PTSD to Rwanda inevitably brings with it these assumptions. At first glance, the concept of PTG would seem to offer a different perspective, particularly in relation to the third criticism as it clearly offers a positive psychological viewpoint. However, the concept of PTG is not immune to these same criticisms insofar as researchers and clinicians schooled in the medical model have brought them implicitly to the study and practice of PTG, similarly looking for characteristics within the person that impede PTG, how to provide expert based interventions to promote PTG, and only viewing PTG as beneficial and worth attention insofar as it leads to reduction in more traditional outcomes such as PTSD. As such, the challenge as I see it in developing a new agenda for the application of trauma psychology to Rwanda is not

which of these concepts (i.e., PTSD or PTG) is more appropriate, but which epistemological assumptions from which to approach the work. As a humanistic psychologist, the medical model applied to psychological experiences seems flawed regardless of whether one is discussing PTSD or PTG.

As opposed to viewing experiences from the medical model, an alternative is the humanistic person-centered approach. This is a based on a potentiality model; rather than viewing growth in the sense that economics uses the term to mean an increase, the term growth is used in its biological sense in which things develop to their best potential. In the following section I will consider the concept of PTG from the perspective of humanistic person-centered theory.

Rogers (1959), the originator of the humanistic person-centered approach, proposed that human beings have a natural and normal propensity towards the development of their potential. Rogers referred to this as the tendency towards actualization. Rogers (1959) contended that the actualizing tendency was inherent in all people, who as a consequence are continually motivated toward reconciling incongruence between self and experience, in such a way as to develop, maintain, and enhance the organism. This is an automatic process that occurs when no constraints are placed on the tendency towards actualization.

Specifically, Rogers (1957) held that in a social environment characterized by genuineness, empathy, unconditional positive regard, people will develop unconditional positive self-regard, and thus unhindered by defenses and distortions, will self-actualize in a direction toward becoming what he referred to as fully functioning human beings.

In emphasizing the power of unconditional positive self-regard regard, Rogers' attention was focused on two basic human psychological needs. First, we have the need to be autonomous, free to choose our own path without feeling controlled, hence the need for unconditionality from others. Second, we need to have a sense of belonging, hence the need for positive regard from others. We are social creatures with a basic need for connection and

belonging. Having these needs met is vital for healthy development, especially early in life, but also throughout life these continue to be important.

As such, the humanistic person-centered approach is in direct opposition to each of these three features of the medical model described above. First, humanistic person-centered therapists are concerned with the social systems and how external forces act on the person, leading to the development of psychological problems, and in turn the provision of social relationships as the way to facilitate growth. Second, there is no need for specific diagnosis and prescription of specific treatments as psychological problems result from this same underlying cause of thwarted potentiality; thus, they focus on the client as expert on what is best for them. The therapist is non-directive because the direction comes from the client, hence the term person-centered. Third, humanistic person-centered therapists are interested in the constructive and healthy potential of people for its own value.

As such, the question is whether to approach human experience from the mindset of the medical model or the potentially model of the humanistic person-centered approach. The experiences that are described by the definitions of PTSD, i.e., the intrusive thoughts, avoidance, anxiety, and that of PTG, i.e., the change in philosophy of life, deepening of relationships, and changes in self-perception, are generally already theorized and researched from the medical model. I will describe below they can equally well be theorized from the humanistic person-centered school of thought.

Rogers (1959) was writing two decades before the introduction of the diagnostic category of PTSD but, as first described by Joseph (2005), he provided a theory that accounted for the same experiences that were later described by this diagnosis. In short, traumatic events demonstrate incongruence between self and experience, leading to the process of breakdown and disorganization, and the need to accurately symbolize the new experience in awareness. Rogers (1959) described the anxiety that is experienced as

incongruence is subceived[3] and how as the self-structure breaks down the person attempts to deny their experiences and hold onto their pre-existing self-structure, and on the other hand, to accurately symbolize in awareness their experience. Human beings have a need to make meaning of their traumatic experiences, and until this takes place their mental world is given over to overwhelming and distressing intrusive thoughts coupled with attempts to regulate these distressing and overwhelming thoughts through avoidance. Rogers description of breakdown and disorganization is remarkably similar to more contemporary theories of psychological trauma which emphasize the need people have to rebuild their shattered assumptions (see, Joseph, 2005).

In Janoff-Bulman's (1992) theory of shattered assumptions, people rely on a set of assumptions to guide their understanding of themselves and the world, namely that the world is predictable, meaningful and benevolent. What makes an event traumatic is that it shatters these assumptions. Janoff-Bulman was concerned with providing an explanatory account for why people experience posttraumatic stress, but subsequent theorists have adopted her ideas as the foundation for their theories of PTG (Tedeschi & Calhoun, 2004; Joseph & Linley, 2005).

Applying shattered assumptions theory to Rwanda seems most applicable, given the failure of previously trusted institutions, family, friends, and neighbors, to provide safety and who even participated in the killings. For example, in a qualitative study of 20 survivors, Dushimirimana, Sezibera, and Auerbach found that this was a theme expressed by many, e.g., "…we went to the church but killers came behind us, we thought it could be safe but it wasn't" (p. 223).

[3] Subceived is a term used by Rogers (1959) to refer to how human beings can be aware of information without it being in direct awareness, a form of situationally accessible memory as opposed to verbally accessible memory.

However, what was unique about Rogers' (1959) approach was that he was attempting to not only explain the development of distress and dysfunction, but how this was also an intrinsically motivated process towards congruence between self and experience, which in this context can be described as PTG. PTG, as understood from the person-centered approach, is a way of describing the psychological functioning that arises when there is increased congruence between self and experience, as happens when needs for autonomy and belongingness are met (see also, Joseph, 2015).

The organismic valuing process (OVP) theory of posttraumatic stress and growth proposed by Joseph and Linley (2005) is a direct application of Rogers' (1959) explanation of the process of breakdown and disorganization of the self-structure to understanding traumatic stress. OVP theory is a person-centered theory of PTG that posits: 1. that people are intrinsically motivated towards posttraumatic growth; 2. that posttraumatic stress is a normal and natural processes that triggers growth; and 3 that growth is not inevitable but a process which is influenced by the social world and the support that is available that can help or hinder affective-cognitive processing.

As such, OVP theory predicts that unconditional self-acceptance allows people to accommodate their trauma-related experiences. Trauma presents people with new information about themselves and the world that may be incongruent with their self-structure, as suggested by Janoff-Bulman (1992). For example, trauma-related information may be that events in the world can happen randomly and outside one's control, which is challenging for a person with unrealistically strong beliefs in the justice and controllability of the world. It is this incongruence that gives rise to posttraumatic stress, which is characterized by the presence of intrusive thoughts and attempts at avoidance.

However, the experiences associated with the diagnostic category of PTSD are not expressions of a disorder but of a normal and natural process that is intrinsic to the

development of PTG. Human beings are intrinsically motivated toward activities that are both personally and socially constructive. How these two basic needs are expressed inevitably varies from culture to culture. Western society may more strongly emphasize the need for autonomy compared to Rwanda which is more community oriented. In Rwanda, interpersonal relations and social customs are the pillar of community life (Grayson, 2017). One might therefore expect that the nature of PTG in Rwanda is less individualistic and more oriented towards positive social change. As such, it is a theoretical perspective which implies that the processes of individual and national healing, reconciliation and development are inextricably linked.

APPLICATION TO THE BROADER SOCIAL PROCESSES OF POST-CONFLICT HEALING, RECONCILIATION AND DEVELOPMENT

Our research project is coming to an end. Preparations are now underway for the final visit to Kigali and the Genocide Archive of Rwanda at which time we will hold a workshop to share our findings with therapists and other helping professionals. The aim of this workshop will be to discuss the implications of PTG for broader social processes of post-conflict healing, reconciliation and development. The conclusion is that we would want to do this within the framework of the person-centered approach in terms of taking the lead from participants on how to make sense of and use our findings.

This article offers a critical reflection on the application of ideas from the psychology of trauma to non-Western contexts. It has been shown that professionals' ideas about trauma and our responses to it are influenced by social and cultural ideas. The departure from medically-orientated approaches is the humanistic ideal that the resolution of distress may not be as much due to the *techniques* of therapy, but rather as a result of the totality of the relationship

–where human contact and relationship is the curative factor. This is a conclusion echoed by Meichenbaum (2013) in relation to the research on dismantling and specificity based studies into treatments for PTSD, pointing to "…a set of core psychotherapeutic tasks, with the most central being the nature and quality of the therapeutic relationship which accounts for the largest proportion of treatment variance….The therapeutic relationship provides patients with an opportunity to share, reframe and develop the courage to re-expose, re-experience, reengage and review their lives so traumatic events are incorporated into a coherent narrative and a personal accounts" (Meichenbaum, 2013, p. 21).

Although most scholars and practitioners would agree on the importance of the therapeutic relationship, this can mean different things. First, there is the view that the relationship is important because it is necessary to create rapport in order to create compliance with the client in order that they engage with the treatment being provided. Second, there is the view that the relationship is itself the therapy. It is in this latter sense that humanistic person-centered therapists think of the therapeutic relationship (Murphy & Joseph, 2013).

The person-centered approach does not impose any method of intervention beyond the promotion of a genuine, empathic, and unconditional social environment. As such, it does not predefine the condition and bring the cure, but instead values existing traditions and meaning systems, and in this sense is by definition a culturally sensitive approach as the aim of the therapist is purely to offer understanding and acceptance of the client's worldview.

The applications of humanistic person-centered theory provides a focus on the social processes, whether it be in one to one therapy, group encounters, or social interventions; all are concerned with creating the new social environment of acceptance, understanding, and genuineness, that is thought to release the growth promoting potential of people. In this way, the humanistic person-centered approach is more than curative; rather it holds that human beings

are best understood by looking at their potential – a notion at odds with the medicalized deficit models. And as this potential is released, it in turn leads to more socially constructive behaviors. In this sense, it is also a social psychological approach to helping that goes beyond individual therapy.

The expression of the conditions of genuineness, unconditionality and empathy are not techniques to be applied but a philosophy of how to live one's life and relate to others. It seems likely that these values are sufficiently consistent with those of Rwandan society. For example, in some interviews, survivors reported that reconciliation would only result from sustained interaction and cooperation between perpetrators and survivors (Clark, 2014). Reconciliation has been an important part of RPF government policy, involving the rehabilitation of perpetrators and promoting the healing of survivors (Zorbas, 2004). In 2005 the government introduced the *gacaca* community court system, a 'grass-roots' participatory justice system, in which it was hoped that dialogue enabled between groups and a commitment to work towards common goals of justice would help to restore unity within local communities (Clark, 2010). In their thematic analysis of survivors, Dushimirimana, Sezibera, and Auerbach (2014) identify context specific resources that were helpful to survivors in creating their new life.

The first of these was the safety provided by the Genocide Survivors Support and Assistance Fund (FARG) which provides support in of education, health, shelter, social assistance and income generation; and the AERG which is an organization run by students for students dedicated to providing financial support, moral help, fighting genocide ideology and ensuring that students overcome trauma, homelessness and financial problems; and the sense of justice the *gacaca* system provided. The gacaca courts are based on a traditional Rwandan system for resolving disputes. The word gacaca refers to a bed of soft green grass

on which a community and leaders known for their integrity and wisdom gathered to discuss and resolve disputes within or between families and members of the same community.[4]

The second was connection and support, the recognition that Rwandan society is a collective one, that is about mutual support. Other research with survivors and perpetrators carried out before and after their participation in *gacaca* trials, supports the notion that such social rituals are important for transforming emotions and enhancing social integration (Rime et al, 2011), which in turn is known to be associated with lower trauma symptoms (Rieder & Elbert, 2013).

A humanistic person-centered approach seems consistent with these existing cultural institutions, but it is possible that bringing additional expertise and training to professionals in Rwanda about the person-centered approach may be helpful, in how to make best use of these social institutions to promote healing, reconciliation, and development through the more deliberate cultivation of the approach within these existing systems. The person-centered approach towards conflict resolution is well established already. Rogers was nominated in 1987 shortly before his death for the Nobel Peace Prize for his work with national intergroup conflict in South Africa and Northern Ireland (Kirschenbaum, 2007). In working with traumatized groups of people, Rogers would of course not have referred to this as the facilitation of PTG as this was before the term was coined, but as I hope should be clear, this is in essence exactly what he was doing. However, his would inevitably have been a view of PTG in the biological sense rather than the economic sense, and in the sense that as people become more fully functioning they also become not only more autonomous as individuals but socially constructive .

[4] http://gacaca.rw/about/

Thus, in holding a workshop to share our findings with therapists and other helping professionals in Rwanda we wish to share our findings and observations about PTG but at the same time we are mindful about how this important idea can be conveyed either in the economic sense and framed from a medical model perspective or in the biological sense grounded in humanistic person-centered theory. How PTG is applied in practice ultimately rests on which of these positions is adopted.

Within a Western context, there is much research on treatment protocols using various therapies, and diagnostic categories, and consequently there has been interest in whether and how these can be adapted for the Rwandan context. While not wishing to rule out such work altogether as undoubtedly this will lead to needed help for many people, the observation of PTG leads me to consider the benefits of the humanistic person-centered approach, as a way to contribute to broader processes of post-conflict healing, reconciliation and development. In the case of Rwandan individuals, it seems likely that growth at the level of the individual is influenced by, and in turn influences, societal development, and a humanistic person-centered approach to understanding trauma may aid this process.

There are also implications for research. While the underpinning notion of PTG as representing positive changes in relation to traumatic experience seems to apply across diverse religions and cultures (Splevins et al., 2010), the actual lessons to be learned as a result of trauma, the meanings that must be accommodated with existing assumptions, will invariably reflect cultural patterns.

It is important that we are mindful not to create expectations for PTG, but instead promote respect for the difficulty of trauma recovery while allowing for the exploration of possibilities for various kinds of change even in those who have suffered greatly. For this reason we think it important that new research and practice is grounded in the experiences of the people themselves rather than pre-defined ideas of what PTG consists of. It is important

from the humanistic person-centered perspective that any new instruments used in the context of Rwanda for research and practice will be developed on the basis of such cultural knowledge.

Commonly, studies into PTG use self-report tools developed with Western populations to measure individuals' perceptions about the extent to which they have changed on pre-defined dimensions. It is questionable whether such instruments are appropriate cross-culturally (Splevins et al., 2010). Certainly, such instruments can be translated and used, but once an instrument is so developed and respondents are asked to rate items, they can do so whether or not the construct that is being measured exists in that culture, or whether the items are meaningful to them, and other dimensions may exist that are outside the scope of the translation. This seems a particularly important consideration as Rwanda is a more collective society than the western contexts in which much of the previously published research on PTG has taken place. As such it might be expected that newer measures developed from the experiences of Rwandans themselves will be less individualistic in their descriptions of change and instead emphasize to a much greater degree the ways in which people understand themselves as part of a collective society and how PTG is therefore expressed in ways that are socially constructive.

Finally, the completion of this project lies in the future. This article represents our thinking about how to approach our work, the challenges we face as Western researchers and clinicians studying PTG, and how to bring these ideas to our colleagues in Rwanda in such a way that is simultaneously respectful of their experiences. It may be that these reflections are also helpful to other researcher and practitioners faced with similar challenges in other cultural contexts.

ACKNOWLEDGEMENTS

This research was supported by the Arts and Humanities Research Council grant AH/M004155/2

Thanks to Nicki Hitchcott and Hannah Grayson for their comments on an earlier draft of the manuscript and to the reviewers of this paper for their helpful insights.

REFERENCES

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed). Washington, DC: American Psychiatric Press.

Arnold, J. (2011). A Psychological Investigation of Individual and Social Transformations in Post-Genocide Rwanda, in: Provost, R., Akhavan (Eds.), *Confronting Genocide*. Springer Netherlands, pp. 305–317.

Blackie, L. E., Jayawickreme, E., Hitchcott, N., & Joseph, S. (2017). Distinguishing post-traumatic growth from psychological adjustment among Rwandan genocide survivors. In *Varieties of Virtue Ethics* (pp. 299-317). Palgrave Macmillan UK.

Bozarth, J. D., & Motomasa, N. (2017). Searching for the core: the interface of client-centred principles with other therapies. In S. Joseph (Ed.), The Handbook of Person-Centred Therapy and Mental Health: Theory, Research and Practice (pp. 391-408). Ross on Wye: PCCS Books.

Clark, P. (2010). *The Gacaca Courts, Post-Genocide Justice and Reconciliation in Rwanda.* Cambridge University Press.

Clark, P. (2014). Negotiating Reconciliation in Rwanda: Popular Challenges to the Official Discourse of Post-Genocide National Unity. *Journal of Intervention and Statebuilding*, 8 (2014), 303–20.

Dushimirimana, F., Sezibera, V., & Auerbach, C. (2014). Pathways to resilience in post genocide Rwanda: a resources efficacy model. *Intervention*, *12*(2), 219-230.

Grayson, H. (2017). A place for individuals: positive growth in Rwanda. *Eastern African Literary and Cultural Studies*.

Grayson, H., Hitchcott, N., Joseph, S., & Blackie, L (In preparation). *After the Genocide in Rwanda: Testimonies of Violence, Change and Reconciliation*. I. B. Tauris.

Hatzfeld, Jean, *Machete Season: The Killers in Rwanda Speak*, trans. by Linda Coverdale, Reprint edition (New York: Picador USA, 2006).

Janoff-Bulman, R. (1992). *Shattered Assumptions*. Simon and Schuster.

Joseph, S. (2004). Client-centred therapy, posttraumatic stress disorder and posttraumatic growth. Theory and practice. *Psychology and Psychotherapy: Theory, Research, and Practice*, 77, 101-120.

Joseph, S. (2011). *What doesn't kill us: The new psychology of posttraumatic growth*. Basic Books. New York.

Joseph, S. (2015). A Person-Centered Perspective on Working with People Who Have Experienced Psychological Trauma and Helping Them Move Forward to Posttraumatic Growth', *Person-Centered & Experiential Psychotherapies*, 14, 178–90.

Joseph, S. (2017). Taking stock of the person-centred approach and moving forward. In S. Joseph (Ed.), *The Handbook of Person-Centred Therapy and Mental Health: Theory, Research and Practice* (pp. 473-477). Ross on Wye: PCCS Books.

Joseph, S, & Linley, P.A. (2005). Positive Adjustment to Threatening Events: An Organismic Valuing Theory of Growth Through Adversity. Review of General Psychology 9, 262–280. doi:10.1037/1089-2680.9.3.262

Kirschenbaum, H. (2007). *The life and work of Carl Rogers*. Ross-on-Wye: PCCS Books.

Kumar, K., Tardif-Douglin, D. G., Knapp, C., Maynard, K., Manikas, P., & Sheckler, A. (1996). *Rebuilding Postwar Rwanda: The Role of the International Community*. Center for Development and Evaluation, US Agency for International Development.

Levers, L. L., Kamanzi, D., Mukamana, D., Pells, K., & Bhusumane, D. B. (2006). Addressing urgent community mental health needs in Rwanda: Culturally sensitive training interventions. *Journal of Psychology in Africa*, *16*(2), 261-272.

Linley, P.A., Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress* 17, 11–21. doi:10.1023/B:JOTS.0000014671.27856.7e

Maddux, J. E, & Lopez, S. J. (2015). Toward a positive clinical psychology: Deconstructing the illness ideology and constructing an ideology of human strengths and potential in clinical psychology. In S Joseph (eds) *Positive Psychology in Practice. Promoting Human Flourishing in work, Health, Education, and Everyday Life (2nd ed.).* (pp. 411–427). New York: John Wiley.

Magnarella, P. (2002). Explaining Rwanda's 1994 genocide. *Human Rights and Human Welfare*, *2*(1), 25-34.

Meichenbaum, D. (2013). The therapeutic relationship as a common factor: Implications for trauma therapy. In D. Murphy & S. Joseph (Eds.), *Trauma and the therapeutic relationship: approaches to process and practice* (pp. 12 - 24).Palgrave Macmillan: Houndmills.

Munyandamutsa, N., Nkubamugisha, P. M., Gex-Fabry, M., & Eytan, A. (2012). Mental and physical health in Rwanda 14 years after the genocide. *Social psychiatry and psychiatric epidemiology*, *47*(11), 1753-1761.

Murphy, D., & Joseph, S. (2013). Putting the relationship at the heart of trauma therapy. In D. Murphy and S. Joseph (Eds.), *Trauma and the therapeutic relationship: approaches to process and practice* (pp. 1 - 11).Palgrave Macmillan: Houndmills.

McNally, R. J. (2010). Can we salvage the concept of psychological trauma? *The Psychologist*, 23. 386-389.

Pham, P. N., Weinstein, H. M., & Longman, T. (2004). Trauma and PTSD symptoms in Rwanda: implications for attitudes toward justice and reconciliation. *Jama*, *292*(5), 602-612.

Rieder, H., & Elbert, T. (2013). Rwanda–lasting imprints of a genocide: trauma, mental health and psychosocial conditions in survivors, former prisoners and their children. *Conflict and health*, *7*(1), 6.

Rime, B., Kanyangara, P., Yzerbyt, V., & Paez, D. (2011). The impact of Gacaca tribunals in Rwanda: Psychosocial effects of participation in a truth and reconciliation process after a genocide. *European Journal of Social Psychology*, 41, 695-706. doi: 10.1002/ejsp.822

Rogers, CR (1957) The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95–103.

Rogers, CR (1959) A theory of therapy, personality and interpersonal relationships, as developed in the client-centred framework. In S Koch (ed) Psychology: *A study of science,Vol. 3: Formulation of the person and the social context* (pp. 184–256). New York: McGrawHill.

Sanders, P. (2017). Principled and strategic opposition to the medicalization of distress and all of its apparatus. In S. Joseph (Ed.), *The Handbook of Person-Centred Therapy and Mental Health: Theory, Research and Practice* (pp. 11-36). Ross on Wye: PCCS Books.

Schaal, S., Weierstall, R., & Dusingizemungu, J-P., & and Elbert, T (2012). Mental Health 15 Years after the Killings in Rwanda: Imprisoned Perpetrators of the Genocide against the Tutsi versus a Community Sample of Survivors', *Journal of Traumatic Stress*, 25, 446–53.

Splevins, K., Cohen, K., Bowley, J., & Joseph, S. (2010). Theories of Posttraumatic Growth: Cross-Cultural Perspectives', *Journal of Loss and Trauma*, 15, 259–77.

Staub, E. & Vollhardt, J. (2008). Altruism Born of Suffering: The Roots of Caring and Helping After Victimization and Other Trauma. *American Journal of Orthopsychiatry* 78, 267–280. doi:10.1037/a0014223

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social science & medicine*, *48*(10), 1449-1462.

Szasz, T (1961) *The Myth of Mental Illness*. New York: Harper and Row.

Tedeschi, R. G. (1999). Violence Transformed: Posttraumatic Growth in Survivors and Their Societies', *Aggression and Violent Behavior*, 4, 319–41.

Tedeschi, R. G, & Calhoun, L. G. (2004). Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychological Inquiry*, 15, 1–18. doi:10.1207/s15327965pli1501_01

Tedeschi, R.G, & Calhoun, L.G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9, 455–471.doi:10.1007/BF02103658

Weiss, T., & Berger, R. (2010). *Posttraumatic growth and culturally competent practice: Lessons learned from around the globe.* Hoboken, NJ: Wiley.

Williamson, C. (2016). Genocide, masculinity and posttraumatic growth in Rwanda: reconstructing male identity through ndi umunyarwanda. *Journal of Genocide Research* 18, 41–59. doi:10.1080/14623528.2016.1120463

Williamson, C. (2014). Towards a theory of collective posttraumatic growth in Rwanda: The pursuit of agency and communion. *Traumatology: An International Journal* 20, 91–102. doi:10.1037/h0099393

Zorbas, E. (2004). Reconciliation in Post-Genocide Rwanda', *African Journal of Legal Studies*, 1, 29–52

AUTHOR NOTE

Stephen Joseph is professor in the School of Education at the University of Nottingham, England, where he convenes the human flourishing research group. His areas of interest include person-centred psychology, positive psychology, and posttraumatic growth.