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ORIGINAL ARTICLE

Kongera Kwiyubaka (rebuilding ourselves again): Culturally responsive and contextually relevant collective healing in post-genocide Rwanda

Jean Pierre Ndagijimana

University of San Francisco, San Francisco, California, USA

Correspondence
Jean Pierre Ndagijimana, University of San Francisco, San Francisco, CA, USA.
Email: jndagijimana@usfca.edu

Abstract

Drawing on the local experiences, knowledge, and wisdom of Rwandan youth can make them agents of healing from the genocide against the Tutsi in ways that are culturally appropriate, relevant, and meaningful. This qualitative study aimed to develop an emerging framework for intervening with youth that is centered in the experiences and cultural context of the Rwandan youth post-genocide. Drawing on Grounded Action research of post-genocide community-led healing practices with a group of 23 high school students, results indicated that "psychological healing" in post-genocide Rwanda may require different approaches than the dominant Western healing models. For research participants, "healing" meant "*kongera kwiyubaka*" (building ourselves again after the genocide), requiring "*kwigira*" (self-reliance) and "*gusasa inzobe*" (openness to share what is in their hearts). This study recommends that scholars, policy makers, and funders reimagine existing models of healing in post-genocide Rwanda and support local initiatives drawing on wisdom from lived experiences.

KEYWORDS

decolonizing mental health, genocide, kongera kwiyubaka, trauma healing

Highlights

- This study explores culturally specific and decolonial approaches to healing in Rwanda and the importance of homegrown community solutions.
- The concepts, frameworks, and theories the co-researchers of the present study co-generated can be a bridge to decolonize mental health and identify ways to connect with the people of Rwanda more genuinely.
- People with experiencial knowledge are the closest to the problems, they are also the closest to solutions.

INTRODUCTION

Rwanda lost more than 80% of its trained physical and mental health care workers because of the 1994 genocide against the Tutsi (Levers et al., 2006; Ng & Harerimana, 2016). Some were killed while others fled the country. The social fabric was also damaged, which left people with fewer resources to cope with the toxic stress they were experiencing (Levers et al., 2006). As the people of Rwanda rise from the ashes after the tragedies, recovering our mental and physical health is an urgent need and requires ongoing efforts (Rugema et al., 2015). Using a Grounded Action (GA) research approach, I invited Rwandan youth, ages 18–24, who have experienced collective frustrations and painful memories (Human Rights Watch, 2003; Neugebauer et al., 2009; Umubyeyi et al., 2016) in a year-long iterative process to theorize about their own struggles and create their own interventions that bring the healing they wanted to see in their lives. The theories and practices the co-researchers developed have the potential to support economically vulnerable communities while also addressing their mental health needs within a non-stigmatising environment (Schinina et al., 2016). The study offers a cultural insider's lens—a perspective that has been historically ignored or marginalized in theory, practice, and academic discourse.

Research in Rwanda (Munyandamutsa et al., 2012) and in other parts of the world (Harris, 2018) has shown long-term impacts of mental and physical health from prolonged activation of stress associated with historical trauma (Gone et al., 2019) and other ongoing struggles. According to the 2018 National Mental Health Survey (NMHS), the prevalence of mental health disorders in Rwanda, such as depression and posttraumatic stress disorder (PTSD), is increasing both for genocide survivors and the general population (Muneza, 2019). The rise in mental health issues was believed to correlate with the effects of the 1994 genocide against the Tutsi (Nkurunziza, 2019), as well as the lack of effective responses to the problems it caused (Levers et al., 2006; Muneza, 2019). Despite the identified and perceived needs for mental health care services in the post-genocide recovery process (Mukamana & Brysiewicz, 2008; Muneza, 2019; Munyandamutsa et al., 2012), research in Rwanda shows a concerning treatment gap between the number of people who need care and those who receive it (Jansen et al., 2015). For instance, according to the NMHS, while 61.7% of the Rwandan population was aware of where they could get mental health services, only 5.3% had used the services (Muneza, 2019).

While there can be many other reasons that can explain the gap between those needing services and those getting them in the post-genocide Rwanda (Jansen et al., 2015), research investigations show that the reluctance to seek formal mental health care services is partly because dominant Western mental health services are not culturally or contextually appropriate, although they have a strong colonial influence on local professionals who want to secure Western funding (Nyiransekuye, 2011; Watters, 2011). One important example can be found in observing nongovernmental organizations' (NGOs) wide investments in the concept of PTSD in postconflict situations, with the "post" indicating that what they are primarily dealing with are psychological responses to traumatic events that happened in the *past* (Watters, 2011). What the dominant framework does not seem to consider, in addition to its risk to medicalize social sufferings, is that for the people going through complex and ongoing accumulative struggles in addition to the past traumas, the focus on PTSD can be both narrowing and misleading (Clark, 2014). There are people, especially those from economically vulnerable communities, who suffer ongoing and complex traumas, and PTSD may not explain the nuances of their situations (Levers et al., 2006).

Moreover, like other parts of sub-Saharan Africa (Downs, 2016), in post-genocide Rwanda, Cognitive Behavioral Therapy (CBT) has been understood as the best counseling model to treat trauma. Assuming that psychological healing is predominantly about correcting thoughts, feelings, and behaviors through counseling and psychiatric medication and not about accessing food, school fees, mentorship, social connections, employment, dancing, community drumming, informal saving and credit communities, or other forms of creative healing, the CBT framework can be incomplete and sometimes push people away from seeking help (Ndagijimana, 2019; Nyiransekuye, 2011; Schinina et al., 2016). The compartmentalizing framework that separates the needs of the mind from the needs of the stomach can be confusing for Rwandans especially because in the local culture, "a human being is regarded as a whole entity. If the physical body is ill, so will the spirit and mind be ill" and vice versa (Nyiransekuye, 2011, p. 9). Moreover, in post-genocide Rwanda, individual therapies have been understood as a more effective and legitimate approach to deal with trauma than community-based approaches (Jansen et al., 2015; Leach, 2015; Watters, 2011). However, according to Petersen-Coleman and Swaroop (2011), the Rwandan genocidal trauma "was experienced as a group, therefore, adequate trauma interventions needed to be collectivistic in nature and embrace the uniqueness of this small African country" (p. 4). Solomon (2014) asserts that after the loss of loved ones and disruption of social ties, many Rwandans have suffered from isolation, and the dominant Western therapeutic model that attempts to intentionally isolate people further as a form of treatment has caused more harm than good.

The cultural hegemonic aspect of universalization of psychological healing services originating from the dominant Eurocentric framework is not unique to Rwanda and the sub-Saharan region (Watters, 2011). I will be making a comparison to a different cultural context that can be learned from and applied to Rwanda (Gone & Trimble, 2012). In his research with Indian American communities in the United States, Gone (2019) observed that many Indigenous communities mistrust the formal mental health care services with some perceiving it as a tool to ideologically brainwash them and manipulatively force the people to assimilate to a hegemonic culture and reject what is contextually and culturally relevant. Research in Rwanda shows that people avoid formal emotional support services due to similar reasons (Rugema et al., 2015; Solomon, 2014; Umubyeyi, 2015). The power of what Gone (2019) calls *psy-colonization* to influence local ways of knowing and doing has made it difficult for health workers, insiders from the communities, to facilitate genuine healing spaces that do not reproduce the colonial system (Ndagijimana & Taffere, 2020). Despite good intentions, the dominant Western outside-in or top-down prescriptive model is disempowering for vulnerable communities when it explicitly or implicitly forces people from other cultures to assimilate to its Eurocentric approaches and denies them leveraging some useful experiential knowledge (Denborough & Uwihoreye, 2019; Higgs, 2012; Nyiransekuye, 2011).

While many researchers have interrogated the cultural hegemony in mental health care services in post-genocide Rwanda (Leach, 2015; Solomon, 2014; Watters, 2011), little has been done to investigate and suggest homegrown theories of culturally and contextually relevant ways to address the epistemological gaps or the incongruity between formal/dominant mental health epistemologies and practice and the frameworks the community desires in the

post-genocide Rwanda (Jansen et al., 2015). To address the mismatch between the imported mental health care epistemologies and local needs, Denborough and Uwihoreye (2019) recommend that the people of Rwanda and its youth in particular start theorizing their healing needs and play a central role in developing strategies for their recovery.

The current study was driven by the following research questions: What does a Rwandan post-genocide healing process centered on local community knowledge and beliefs look like? What would be the implication for thinking about such programs more broadly? Given the small sample and the qualitative methodology I chose to use, the last question does not intend to generalize findings but to theorize the realities of the specific contexts of the research participants and to raise questions that may need further investigation. The findings generated from the study can inform scholars, practitioners, policy makers, and funders from inside and outside Rwanda who want to contribute through culturally appropriate and locally welcomed means.

LITERATURE REVIEW

This literature review explores the situation of the younger generation born during or shortly after the genocide and their efforts at recovery. It critiques the cultural hegemonic aspects of dominant Western psychological healing epistemologies in post-genocide Rwanda and how they have interrupted local ways of naming psychosocial struggles and organic traditional support systems. It also explores homegrown strategies with a focus on local ideals of psychosocial support.

Post-genocide youth

Rwanda experienced many internal and external conflicts stemming from the past decades of colonialism, divisions, and lack of tolerance (Prunier, 1997). The accumulation of hate and violence led to the 1994 genocide against the Tutsi (Hintjens, 2001). In the aftermath, the people of Rwanda have had to coexist (Abiosseh et al., 2019), "murderers, survivors, and others all live cheek by jowl in a small, crowded country" (Donahue, 2014, para. 8). In 2018, around 70% of the Rwandan population was under 30 years old, and 60% were born after the 1994 genocide against the Tutsi. Although they were not perpetrators themselves, children of the *genocidaires* are recipients of collective and individual blame and anger. Young Rwandans are painfully aware and frustrated by the role their relatives played in the suffering (Parens, 2009). On the other hand, some younger genocide survivors and those who were born into families who survived the tragedies, have had to rely on rare old pictures to know what their deceased family members looked like (Ndagijimana, 2019). Others experienced some relief if they received information about their murdered loved ones, such as the location of the mass graves where they were buried, so they could rebury them in the communal memorial sites that are spread across the country (Kaplan, 2013; Wallace et al., 2014).

According to what is generally believed to cause trauma, one could conclude that all Rwandans who experienced the genocide against the Tutsi in one way or the other experienced trauma (Levers et al., 2006). "This is not to suggest the need for a collective diagnosis or to pathologize Rwandans' responses, but rather, to underscore the severity of most citizens' experiences during the time of genocide" and acknowledge the resilience the people have shown in the aftermath (Levers et al., 2006, p. 263). Rape and other forms of dehumanization constitute the unspeakable experiences that have seemed to complicate the healing process for some communities (Rights, 2004). According to Ng and Harerimana (2016), an estimated 250,000 Rwandan women were raped during the genocide, and sources estimate that 2000 to more than 10,000 children were born as a consequence (Mukangendo, 2007; Rights, 2004). Those children face unique barriers to their healing journeys (Kantengwa, 2014). The social stigma they and their mothers experience makes it hard for researchers to collect accurate data about them (Rights, 2004). Some of the younger population experience an identity crisis, a lack of belonging, and unanswered questions about their biological fathers and heritage (Denov et al., 2017). They have been stigmatized for being the children of "*umwanzi*" or "*interahamwe*" (killers). Some community members believe these children are undeserving of parental love and care (Rights, 2004). While the Rwandan government has done much to support vulnerable populations (Kang et al., 2020), little is known about how the youth are negotiating their identities, relationships, and recovery (Denov et al., 2017).

In post-genocide Rwanda, the most disturbing triggers to the memories of the younger generation, and especially those living in poverty, are fundamental needs that go unmet because their resources have been destroyed (Betancourt et al., 2011; Ndagijimana, 2019). Locally, when one looks depressed and especially when from a lower-income family, it is likely that those around the person will wonder if the sufferer is meeting their basic needs. Generally, the culture does not distinguish the needs of the mind from the needs of the body (Nyiransekuye, 2011). That is especially because the inability to access essential needs can be a contributing factor or a consequence of the emotional disturbance (Ndagijimana, 2019).

Chaste Uwihanganye has been engaging with the younger population's healing journeys since early after the genocide against the Tutsi. He suggests that to meet Rwandans where they are, local scholars, and practioners need to create a center that develops healing resources and frameworks that honor local ways of knowing and doing (Denborough & Uwihoreye, 2019). Similarly, in recent years, researchers and practitioners in the West and especially those serving Indigenous (Gone & Trimble, 2012)

and immigrant populations in the United States (Fernández et al., 2020) have also been interrogating the hegemonic and monolithic aspect of the dominant framework of psychotherapy and have started developing more varieties of resources to meet their diverse communities' demands (Gone et al., 2020; Haines, 2019). For example, at the Mental Health Clubhouses in Hawai'i, clients and staff members engage in nonhierarchical collaboration to collectively define and achieve wellness with dignity and mutual respect (Agner et al., 2020). In Rwanda, a longitudinal study by Kang et al. (2020) demonstrated that practices grounded in the people's culture and context such as raising cows together has the potential to promote reconciliation and healing between genocidaires and survivors.

In Rwanda post-genocide, Leach (2015) suggests that "the best experts to bridge the gap between international and local experiences are those who might not have a health or psychology background but have deep knowledge about cultural differences" (para. 15). In the country, efforts that center mutual care, community building, and peer to peer support have shown promising results (Denborough & Uwihoreye, 2019; Ndagijimana, 2019). Naming the problem (diagnosis) and generating solutions (prescriptions) for the identified problem, all using Rwandan concepts, have shown great impacts in healing the post-genocide younger generation (Denborough & Uwihoreye, 2019). However, such a change needs to be "more than a semantic play with words, but rather a tectonic shift in how we view trauma, its causes and its intervention" (Ginwright, 2018, para. 9). It demands legitimization and support to locally led mental health care and psychosocial frameworks to accelerate the country's recovery process (Jansen et al., 2015).

Homegrown solutions

In the aftermath of the genocide, the Rwandan government understood that given that local people are the closest to the problems, they are also the closest to solutions. Culturally and contextually relevant efforts for the Rwandan recovery process have evolved based on lessons learned through collective experiences and new perspectives (Kang et al., 2020). The government has drawn from its precolonial history, culture, and traditions to develop different citizen-centered homegrown strategies (Haque et al., 2017). These include "*gutabarana*" (literally, mutual rescue). In gutabarana, friends and neighbors get together to provide urgent emotional, financial, and material support to vulnerable people in their neighborhood, for example, those grieving. Gutabarana can also appear in the form of a collective emergency fund, through "*ikimina*" or informal saving and credit cooperatives where people form groups, and members contribute money (King et al., 2017). They meet regularly to check in, discuss their progress, and at the end of each week or month, one of them gets the money they collected (Rwabyoma, 2016). The collective initiatives are also expected to help people *in "kwigira"* or in being self-reliant (Kebongo, 2013). Another example is the "*Girinka Munyarwanda*" (one cow per poor family) program that donates cows for their contribution to the psychosocial well-being and physical nourishment of each poor family (Rwanda Governance Board, 2016).

Centering people's culture, contexts, and engaging communities as the experts of their own lives seem to offer resources and convenient platforms to develop and sustain community-led therapeutic efforts. Nyiransekuye (2011) investigated the work of the Réseau Des Femmes Oeuvrant Pour le Développement Rurale, an all-women's local organization using drumming and weaving to support the community after the genocide against the Tutsi in Rwanda. Most of the women who joined the Urubohero (weaving place) had lost children, husbands, relatives, and family members. At the Urubohero, participants learned how to weave complex patterns, sang, drummed, danced, and offered advice to each other (Nyiransekuye, 2011). The drumbeat and dances centered the women, regulated their stress, and integrated the brain, mind, and soul to create calm. However, according to the researcher, the weaving facility was not explicitly a place for young women to *heal* from trauma but a space for leisure. Consequently, the community interventions such as these are not known or not legitimized by formal mental health service providers (Nyiransekuye, 2011; Watters, 2011). The experiences at Urubohero and other research have cemented the understanding that healing resources do not have to have a *therapy* or *counseling* label to be therapeutic (Ascenso et al., 2018; Wood et al., 2013). According to Levers et al. (2006), we need to learn from the people with lived experiences "so that we can better understand what does and does not work, and so that we can seek culturally appropriate ways for facilitating or constructing resilience and for enhancing naturally occurring protective factors" as well as developing a community psychology programming (Levers et al., 2006, p. 263).

The current study worked with a post-genocide younger generation at a high school in the Western province of Rwanda to develop an iterative process that generated an explanatory theory of the participants' lived experiences, defined their psychosocial needs, designed projects to respond to those needs, implemented the initiatives, and evaluated outcomes. This study offered an opportunity to identify, locate, and cogenerate a Rwandan youth's post-genocide healing process centered on local community knowledge and beliefs. The process, concepts, terms, and frameworks theorized by the research participants from their lived experiences and culture add to the knowledge and conceptualization of psychosocial services in postconflict contexts, community psychology, and decolonial education important in the Rwandan recovery process.

RESEARCH DESIGN

This study employed GA, a rigorous and systematic research methodology that allows research participants to discuss their realities in order for them to define problems

they want to address, frame solutions, and implement them (Simmons & Gregory, 2005). While Grounded Theory (GT) generates theories (Auerbach & Silverstein, 2003; Glaser et al., 1968), GA research generates theories and uses them to develop actions (Simmons & Gregory, 2005). Baskerville and Pries-Heje (1999) interpret GA as an iteration of five steps: (1) Diagnosis, (2) Action planning, (3) Action taking, (4) Evaluation, and (5) Specifying learning. In this study, the stages were iterative and the "specifying learning" was part of all aspects of the project from the beginning to the end. While I primarily used the GA methodology to respond to the first research question (identifying participants' needs, concerns, and ways to help), the second research question (analyzing the data and developing a theory/implication of the developed program) followed a GT data analysis protocol developed by Auerbach and Silverstein (2003).

Participants

In total, 23 students (12 males, 11 females) in a public and boarding high school in Rwanda Western Province, all of whom were 18–24 years of age, participated in the study. For a student to participate, they had to be 18 years minimum and studying in upper high school. Many of them (20 of the 23) self-identify as Christians. Eighteen of the participants were from farming families in rural areas. Thirteen of them said they had difficulties affording enough food at school and 11 said they do not get enough meals both at school and at home. A few of them are part of the Genocide Survivors Students Association (AERG) at the school. Others said that while they were not the target of the 1994 genocide, the experiences have directly impacted them (i.e., relatives imprisoned for their roles in the genocide, past and present hardships, the latter was a shared concern).

Using a purposeful sampling method, the teacher who was assigned by the head of the school to assist me in the process helped select 10 students from six classes based on knowledge about the compatibility of my project and the students' needs. The "compatibility" in this sense meant the teacher's perception of a student's need for healing resources. This was based on the information the teacher already had about the students. I did not, however, ask the teacher to report to me the reasons he selected each individual student. Later, using snowball sampling, the existing participants invited five of their classmates to join the project in separate focus group conversations. The newer group then invited five more students for additional focus group conversations. The idea was to see if the new participants might contribute information that could alter or change the theory (post-genocide youth community-led healing framework) that was under development. To select the newer groups, the existing participants shared about candidates whom they believed would find such types of conversations beneficial to them. We invited those that most of the existing participants said they would want them to join the team. As they invited the newer groups, they told the later that they are invited to discuss their shared struggles and to brainstom solutions to them.

Toward the end of the initial focus groups, a meeting was convened with all three groups, and they collectively decided to invite three more students because of their unique experiences in leadership, entrepreneurship, and bringing everyone together; skills they said they wanted moving forward. To recruit the three new members, a delegation of three students from the existing groups reached out to the candidates and shared with them a bit about what had already been done, and why their contribution is needed. They told the potential candidates that they were being invited because of their skill sets and that if they chose to join, they would be expected to engage their technical skills in the project that was under development. After this stage, no new information was generated, and research participants agreed that there was no need to invite new participants. While the participants would not describe themselves as needing mental health services (findings tie this to the mental health stigma) and the project was never explicitly discussed in mental health terms, they were eager to be part of the community discussing the shared struggles and what they could do to help each other.

Researcher positionality

I grew up in Rwanda and had previously attended and worked for the school where the study took place. I am a locally trained clinical psychologist and a local counseling practitioner. I was raised in the neighborhood, and before this study, I was aware of some shared experiences, such as living conditions and cultural traditions.

Project

This project worked with a local community to cogenerate healing resources and put them into practice. I initially met the students in mid-2018, and the project lasted for 12 months. Throughout the month of June 2018, I met the students once a week on Sundays. As the project embarked and throughout the process, my intention was primarily to work with the post-genocide youth and leverage their experiential knowledge to develop a locally led theoretical explanation and actions that authentically respond to their healing needs. The research part of the overall project was to document participants' organic insights related to psychosocial recovery mechanisms. The discussions followed an iterative process (Baskerville & Pries-Heje, 1999). First, we engaged in conversations to define common psychosocial problems and their impact on the participants' lives (Diagnosis). After this stage, the research participants said that there were some conversations they would prefer to have without me. A leadership committee they had selected told me this was so that they could comfortably bounce ideas with each other and authentically voice their needs. After meeting on their own, they invited me to the next and

shared that they decided to do something about the issues they had identified (Action planning). They decided that they needed to initiate a club and created a leadership committee led by three students and selected one of their entrepreneurship teachers to be their day-to-day supervisor (Action taking). This was followed by the implementation of their project from July 2018 to May 2019 (Action taking). At that point, the students conducted an evaluation with a volunteer who offered to assist me in facilitating the discussion (Evaluation/interim data collection). The research data grew out of this process, and the students' project continued beyond the research period.

Data collection

While this was explicitly a research project, I had an intention to center mutual benefits. Most of the activities purported not to *just* collect data but to offer a supportive space for the post-genocide youth to theorize and practice healing frameworks that feel most authentic to them.

The iterative stages of the project, data collection, and coding all happened simultaneously. Since the purpose of the project was not merely a "data collection" process but identifying, locating, cogenerating, and amplifying healing resources, to practice them and evaluate them, the number of sessions were not predefined. We had to stick together until our conversations led to a mutually beneficial outcome. The initial conversations lasted for five sessions plus three more sessions that happened three, seven, and 12 months after for evaluations. Throughout the year, they also met independently to discuss the project and I did not require them to record their conversations or to report them to me.

Our relationship was guided by an organic process and the choice was culturally and contextually appropriate. Structures of conversations were semiguided. While I had a written backup plan, I allowed the GT of community-led healing framework to grow organically. I started the conversations by asking the participants to describe a typical community member who needs healing. After this prompt, the conversations constituted an organic process that ranged from defining the problem to suggesting solutions and expanding to the larger community the individual represents. In addition to observations and field notes, I audio-recorded data during individual interviews, focus group conversations, and discussions in the larger group at the start of the project, and three, seven, and 12 months later.

Participants referred to the discussion in the larger group as a time for "*ijambo*" (the sacred, uninterrupted time where individuals in the culture take turns to speak on individual perspectives around a given topic within a supportive community). Participants were in a classroom setting, sitting in a large half-circle facing a blackboard. There were two students on each bench. Sometimes due to the sensitivity of a conversation (i.e., when sharing some personal sensitive information such as those related to personal and family vulnerabilities, when criticizing teachers or the school administration, or talking about some other sensitive topics such as those related to ethnicity and the genocide) participants required some privacy. They could take blank papers and walk to an open space outside and produce written notes with the information they preferred not to share publicly. Throughout the process, in addition to focus group discussions and individual conversations, I also collected data through WhatsApp group chats, phone calls, and letters especially with the students' leadership team giving me updates about what they were observing from the project. The remote communication was important especially because I was only with the group physically for the first month and returned after seven months.

Before we started any new focus group session, I stood in front of the class with some chalk, wrote on the blackboard, recalled what happened in the previous session, and asked them to verify relationships between variables. I had to visually draw the theory so far constructed to confirm that we were all on the same page about the production of a post-genocide Rwanda youth's theory of community-led healing practices. We agreed that they will be able to read and validate or suggest that I change or remove anything before I share any writing from the study to the public eye. I have fulfilled the promise.

Data analysis

While the project development followed a GA framework (Baskerville & Pries-Heje, 1999), the data analysis process followed a GT coding procedure developed by Auerbach and Silverstein (2003), moving from a lower, more concrete to a higher, more abstract level of understanding. I read each transcript multiple times with the participants' research concerns in mind. The coding process to cogenerate a GT of post-genocide youth community-led healing practices and the development of the project happened simultaneously. In GT, the data related to research concerns is called *relevant text* (Auerbach & Silverstein, 2003), and that information was highlighted. After this stage, I compiled the texts I thought were most relevant and I set aside the remaining data. I grouped the relevant texts with similar words, phrases, and messages as *repeating ideas*. I grouped into *themes* repeating ideas that emerged across multiple focus groups or among at least 50% of the entire participants. In the same way, I grouped themes that had common messages into *theoretical constructs*. I then arranged the theoretical constructs into a *theoretical narrative*, which serves as the summary of the lessons learned from the research. To honor the nonlinear analysis approach, we moved back and forth between the steps.

RESULTS

The following results are relayed here as a theoretical narrative of youth community-led healing framework in post-genocide Rwanda based on three constructs that emerged from the bottom-up coding process. What follows

is a narrative divided into sections highlighting each theoretical construct. The narrative is chronological, starting at the beginning of our work together through its conclusion. The work's chronology corresponds to the theoretical constructs. The earliest part illustrates the first construct: building the foundation for working together. Based on that foundation, the research participants developed the second construct: a community-led description of the problem. Their ongoing work after that represents the third construct: finding solutions from within. Table 1 illustrates themes (emerged from repeated ideas) and the theoretical constructs that resulted from the themes. The summary constitutes the project partners' theoretical explanation of a community-driven framework of post-genocide psychosocial recovery.

In relaying the theoretical narrative, I will put repeated ideas that led to the themes and, ultimately, to the theoretical constructs that organize this narrative, in quotation marks. Within these quoted sections, I use the third person plural (they, them, their) to represent the plurality of the participants who shared these views, and so I can remain in the position of retelling others' stories. Though the words may be the quotation of one person using the first person singular, because the idea was heard repeatedly, I have retold it in the third person to indicate the plurality of people thinking and talking that way. I kept some of the words and idioms in the original language. With the intention of ensuring the story is expressed in the participants' own words, I used as many participants' original words as possible with their English translations in parentheses. By convention (Auerbach & Silverstein, 2003), within the texts, I put themes in italics and bold font.

TABLE 1 Themes and constructs for a theoretical framework for psychosocial intervention

I. Building the foundation for working together

- **A.** Addressing conflicts as the point of departure.
- **B.** Community problem co-ownership and gutahiriza umugozi umwe (synergy and mutuality).

II. Community-led description of the problem

- **A.** Guheranwa n'agahinda (feeling stuck in depression).
- **B.** Kubura epfo na ruguru (experiences of extreme poverty and helplessness).
- **C.** The distinction between counseling and ubufashamyumvire (awareness facilitation).

III. Kwishakamo ibisubizo (finding solutions from within)

- **A.** Gusasa inzobe (speaking the truth about how they are feeling) and avoiding kurenzaho (pretending there is no conflict or problem when there is).
- **B.** Kongera kwiyubaka no kwigira (building themselves again and self-reliance).

Note: This table illustrates the major components of an iterative process of a youth-led post-genocide psychosocial recovery framework, which starts from (a) building relationships and addressing real or assumed conflicts as the foundation for working together to meet their individual and collective needs, (b) centering a community-led effort and engaging the service users in theorizing their experiences and defining their desires, and (c) centering their ways of knowing and doing and generating strategies to address the problems they defined.

Building the foundation for working together

The construct of building the foundation consisted of resolving explicit and implicit internalized conflicts among the research participants, agreeing on strategies to resolve future misunderstandings in the group, defining values to guide the group, and developing detailed expectations from each partner for the success of the collective. ***Addressing conflicts as the point of departure*** is the first theme of this construct. When the high school students and I started our conversations, many of them reiterated that "there were some fundamental factors they needed to take seriously for the success of the focus group." Using local proverbs, they said "*ahari abantu hanuka uruntu runtu*" (where there are people, there are conflicts), and "*nta zibana zidakomanya amahembe*" (no cows live together without rubbing horns). The participants agreed that conflicts may be inevitable, however, "*ahari abantu nti hapfa abandi*" (where there are humans, those who are vulnerable among them should not die).

By potentially drawing from lived pains, one used an example to explain why resolving conflicts is the foundation, "your family did some bad things to my family, and seeing you is always reminiscent of what your family did to me. To resolve the problem, I can kill you so that I cannot continue seeing you and get constantly reminded about what your family did to me." Consequently, everyone was encouraged not to "*kurenzaho*" (hide conflicts and pains) by "*gusasa inzobe*" (speaking the truth as it is in their hearts). They decided to avoid "*amacakubiri*" (divisive behaviors), and when a conflict arose, they suggested engaging mutual friends in finding solutions. "*Kwicara hamwe*" (sitting together) while they are "*gusangira*" (sharing meals/drinks together) was suggested as the most effective platform to handle difficult situations.

The second theme in this theoretical construct is ***to promote community problem co-ownership through "gutahiriza umagozi umwe"*** (synergy and mutuality). For the research participants, no one should suffer alone. "We have to combine our efforts and support each other as if what happens to one of us happens to everyone else in our community." In a practical way, "if a group member's mother dies, it is as if the mother for all of us dies. It is as if all of us are experiencing the same problem, and we have to respond accordingly."

Community-led description of the problem

This construct consisted of defining what their common stressors are and how these experiences impact their lives. The theoretical construct was generated from three themes: The first was ***"guheranwa n'agahinda"*** (feeling stuck in depression) or ***"guheranwa n'amateka"*** (feeling stuck in history). According to the research participants, there are people who have experienced horrifying events like genocide, wars, serious illnesses, "*kubura epho na ruguru*" (losing the north and the south or the state of extreme poverty

and helplessness), drug abuse, and many more, and they have never been able to recover. These people are feeling stuck in depression, and for these high school students, the *feeling stuck in depression syndrome* is heavier than the common response to usual difficulties known as "*guhangayika*" (stress). For the youth, while *stress* results from "*imihangayiko*" (stressors) which can be temporary, feeling stuck in depression results from "*inzira y'umusaraba*" (bearing a burden). In their definition, "bearing a burden" is persistent accumulative stress from continuous tragic experiences. However, they also agreed that prolonged and sustained stress with no supportive community to buffer it can lead to feeling stuck in depression.

Because of the socially undesirable attitudes of those with the feeling stuck in depression, the research participants metaphorically compared these people to "*ibirayi biboze*" (rotten potatoes), and they expressed concerns about how they would take care of the person given that they would not throw him/her away as they would a rotten potato. They added that while potatoes rot due to physical or environmental reasons, the most common causes of feeling stuck in depression are genocide, wars, accidents, poverty, not having friends, losing parents at an early age, the divorce of one's parents, death of someone on whom one depended for a living, illnesses, or imprisonment.

The conversation around how they usually prevent a potato that is harmed from rotting seemed to trigger and inspire conversations around how they could also take care of their community members struggling. For instance, when I asked what they would do with one among them who might be feeling stuck in depression, they first cycled back to the story of a rotten potato. Some said that when they are taking care of their harvests (potatoes), those that are harmed are given special attention, making sure they do not experience humidity and they only expose them to an adequate amount of sun. "They added that they would also need to know the potato's whereabouts and how it is doing to make sure it does not deteriorate and affect the rest of the potatoes." Similarly, they agreed that "to help the person who is feeling stuck in depression, it would require that person *to tell the truth about everything, including their vulnerabilities* because some suffer internally and never reveal this to anyone." For the research participants, the person who is feeling stuck in depression feels like "*nta gira uwo abwira*" (they have no one to tell). This is because they fear asking for support, and they are likely to ignore advice from anyone who has not gone through what they have experienced. They agreed to provide special care to those among them who are most vulnerable.

The second theme that informed this theoretical construct was ***"kubura helpfo na ruguru"*** (losing the north and the south or prolonged vulnerability and helplessness). The most reported deleterious sources of *losing the north and the south* were family issues and the inability to financially satisfy their fundamental needs, while also experiencing "*ubwigunge*" (loneliness). Several participants agreed that those who chronically suffer from feeling stuck in depression are likely to be poor.

The third theme in this theoretical construct was ***the distinction between counseling and "ubufashamyumvire"*** (awareness facilitation). They clarified that the conversations in our focus groups were not "counseling" but "*guhugurana*" (training one another). They said that none of them were suffering from mental health problems, even though they agreed that they all experience stress. They said I was for them an "awareness facilitator" and not a "counselor" and that the reasons why they wanted to distance themselves from the concepts (counselor and counseling) are that the terms are attached to the mental health stigma. They clarified that while a counselor deals with mental health issues, the term "awareness facilitator" means someone who helps and trains others to develop a different way of understanding. They explained that while the term "counselor" implies the existence of a mental health client, an awareness facilitator implies that the people are engaged in a collaborative activity of sharing experiences and learning. They said that for the fear of stigma, if I had invited them to come for "counseling," none of them would have accepted to join the program. However, they also highlighted that although they would not want to call our conversations "counseling," the discussions throughout the project had a therapeutic effect on them. They concluded that "counseling can be embedded in the awareness facilitation when it allows participants '*kwividura*' (pouring out)" their heavy emotions.

Kwishakamo ibisubizo (finding solutions from within)

This construct developed as we continued our discussions. Some research participants started to ask if our end goal was "*kuvuga ibibazo gusa*" (just talking about problems). They collectively agreed that they had enough discussion of problems. They stated that "the best strategy to find solutions to the problems was '*kwishakamo ibisubizo*' (to find solutions from within themselves) and to reach out if they needed support from me." The participants suggested that during the next session they meet without me. I approved the request. After their own meeting, they invited me to the following one. They emphasized that moving forward, they would prefer to be referred to as "*abafatanyabikorwa*" (project partners) rather than my "research participants." To honor their request, moving forward in the narrative, I use *project partners* instead of research participants.

The project partners also agreed that to build the foundation necessary for the success of the solutions they were generating, it was crucial for them to be open to each other and share their conflicts, pains, and vulnerabilities. These conversations constituted a theme we named ***"gusasa inzobe"*** **(speaking the truth about how they are feeling) and avoiding** ***"kurenzaho"*** (pretending there is no conflict or problem when there is). Project partners wanted to share with each other their life experiences, including issues in their lives—not just superficial information. For the project partners, however, "without the financial ability to buy a

meal or bring milk to a community member who is sick, the newly created group could not help them *kongera kwiyubaka* (rebuilding themselves again)," they warned. They recognized that "they would not be able to help one coping with stress by just offering '*ubujyanama*' (counseling) when the student is sick and needs food or a cup of tea and cannot afford it." The personal financial realities, which some of them shared through sealed letters constituted the justification for them to suggest a collective income-generating project of raising rabbits to facilitate *kwigira* (communal economic self-reliance).

Rabbit project

The project partners defined the rabbit project as "a platform for them to work together towards a common goal." They agreed that the project "is a way for them to care and support one another." They wrote a budget for the project and shared it with me after consulting their entrepreneurship teachers. To implement the social business, they decided that everyone would be contributing $4 at the beginning of each semester ($12 a year). They asked me to financially contribute to the development of their rabbit business project and I did. They started with 54 rabbits. They hired some community members from the school neighborhood and built a hutch together. They collaborated with the local government to find a veterinarian, and they wrote a contract with him to visit the project monthly. When I met them in person to evaluate the project seven months later after the rabbit project had started, the partners said that "the rabbit project created a reason for them to meet and socialize." They agreed that the community business had been an opportunity for them to "***kongera kwiyubaka no kwigira"*** (building themselves again and self-reliance).

Outcome: A collective retrospective reflection

I met the project partners for the third term, a year after the project started. The rabbit population had quadrupled, and the participants had gained valuable practical skills in project development, implementation, and evaluation. Many said they used to isolate themselves and did not have anyone to speak with, but "because of the project they all became close friends." Talking about their experiences, they said, "before the project, there were people they thought they could never speak with, and today they love them." Some stated, "we understand their struggles, and we try to support them. We advise them, and they advise us." In other words, "they are like our siblings." Reflecting on the initial story of "rotten potatoes," they agreed that "they were honored to have exposure to each other's vulnerabilities (rotten potatoes) and to become best friends."

They told me that, methodologically, when one had an intention to support another project partner, they had "*kumubwira ibyanjye*" (to be open and share their own vulnerabilities), and they agreed that this built trust and allowed others to slowly open up to their partners. They agreed that as they opened up to others, they started trusting each other, and those who were usually stoic started to slowly "*gufungukira abandi*" (open up to others). They started "*kwisanzuranaho*" (feeling free and comfortable about approaching one another) and broke kwigunga (loneliness). They claimed that the effort was no longer just a "project" but a "family" because they know each other better and support one another. "They are able to detect when there are some unhealthy changes in fellow group members' lives, and they are quick to initiate support."

The project partners agreed that the initiative "helped them understand how to identify what the real problem is." Using a Rwandan proverb, they said, "*aho kwica gitera wakwica ikibimutera*" (instead of killing the problem, they would rather kill the cause of the problem). They said that when one seems to be going through difficulties, they ask themselves, "what is causing this person's reaction? Is this usual?" They continued that, "when they go in deep and understand '*umuzi w'ikibazo*' (the root of the problem), they sometimes realize the problem is hunger". Thus, "the solution of hunger is to eat. They do their best to make sure the person gets some food to eat. If the problem is about family issues, they try to advise the person."

Financial issues were a gap they were independently not able to fill. They said that when it came to advising each other, they were always equipped with what they needed to help, but they had difficulties affording financial resources for those in need. This situation encouraged them to enhance the business component of the project so they could support those who were most financially vulnerable. The project partners decided that when each one of them finishes school, they will receive a few rabbits from the project so they can replicate it at home. They also agreed to reach out to the school neighborhood and expand the project to include the population that is most emotionally and financially vulnerable.

DISCUSSION

In a response to the increasing mental health-related issues and low-help seeking behaviors in post-genocide Rwanda (Muneza, 2019), this study project worked with Rwandan high school youth to support them in theorizing about their shared needs and to draw from the wisdom that stemmed from their collective experiential knowledge to develop a theory of a local community-led healing framework. The project partners framed solutions grounded in their needs, culture, context, and self-worth. The findings suggest that the initial step in engaging this post-genocide community in their healing process is to create a space that is safe enough for resolving unaddressed conflicts and resentments that might exist or be assumed among the project partners and/or their family members. This foundation allows the next stage to take place, which is for the collective to define their needs. The final major finding from

the study is the youth's need to find solutions from within and to get external support for identified problems that the collective does not have resources to overcome.

The first construct, about addressing conflicts among the project partners, reflects a bigger picture of how the post-genocide younger population is processing and conceptualizing their recovery process. Intriguingly, these concerns around dealing with conflicts became an important part of the project before we even collectively understood what was going to be the focus of our conversations. What I had initially expected to be just an activity to list "ground rules" for our collective space (Arao & Clemens, 2013), became the required pillar for other components of the project to exist. The finding suggests that while bringing people together for a collective cause is a right move, especially in the post-genocide situation, without establishing measures to address unresolved conflicts (real or imagined), getting together can actually be a source of harm including homicides. For instance, alluding to the past of the nation, the students agree that because of their interfamilies' unresolved conflicts, the younger generation can be each other's reminders of the tragedies and that to cope, one may risk taking another's life. Haines (2019) has shown that repeated survival mechanisms once prolonged can develop into some automated habits that may include violent behaviors. In line with previous longitudinal studies in post-genocide Rwanda, activities that promote tolerance and social trust improve psychosocial wellbeing (Abiosseh et al., 2019).

The findings indicate that in the context of this community, to successfully heal and develop together, intentional spaces to resolve real or imagined conflicts are a key for the success of their common goals. This understanding may not be a surprise given that the generation is growing up when Rwanda is still dealing with the direct impacts of the 1994 genocide against the Tutsi (Denborough & Uwihoreye, 2019). Resolving conflicts builds trust, which allows synergy and mutuality as they collectively strive to recover (Abiosseh et al., 2019). In that iterative process, the findings show that once the community can sit together and share their vulnerabilities, pains, acknowledge, and address conflicts or what they called gusasa inzobe, they are then able to move to another step, which is about them defining what issues they have in common that they would want to address for mutual benefits. While they may need some support in thinking through their decisions and financial support to implement their initiatives, they prefer being the one to identify the problem (diagnosing) and suggesting solutions (cogenerating solutions/prescribing) or what they called kwishakamo ibisubizo (finding solutions from within).

Another observation that I had not anticipated, is how the project partners inferred the genocide experiences without pronouncing the word "genocide." They would sometimes say "*ibyabaye*" (what happened) but never explicitly name the experiences. Mistrusts that are rooted in "ethnic" labels devised by the colonizers, the genocide, individual and collective trauma, might be reasons why Rwandans talk about their experiences cautiously and indirectly (Eramian & Denov, 2018; Leach, 2015). The students' discussion complicates Russell's (2019) claim that Rwandans do not speak about their past and the genocide in an open discussion. The current study shows that they do discuss it, but in a way, that one who is not part of the culture may not perceive. The sensitivity of the word "genocide," the memories, shame, pains, anger, frustrations, and concerns it triggers, all may shape how Rwandans speak about their experiences (Buckley-Zistel, 2006).

Findings from the current study go beyond addressing traumatic memories among the younger generation (Umubyeyi et al., 2016), and also reveal what social changes the community wants to see to facilitate their healing process. For the youth, the antidote of kurenzaho (hiding pains, conflicts, and vulnerabilities) is gusasa inzobe (to share the truth about conflicts and vulnerability). However, in this context, sharing one's vulnerability is only safe and dignifying when everyone involved is willing to share. This result ties well with the study by Denborough and Uwihoreye (2019), which suggests the need to create spaces where Rwandan youth converse, cry, and laugh together. The findings also suggest that a community member may feel safe to be vulnerable and draw healing energy only when everyone else present is open to sharing their own situations in the interactive ijambo (the sacred, uninterrupted time where individuals in a group take turns to speak on individual perspectives around a collective concern within a supportive community).

Ijambo may have the form of group therapy. The most important difference between the two is that similar to Mental Health Clubhouses (Agner et al., 2020), Ijambo while formal, is spontaneous, less predictable and less structured. The facilitator exists but may not be obvious and is not necessarily an academically trained person but one whom the community collectively trust. He/she is one among the audience and is expected to share their own experiences in a nonhierarchical (i.e., client vs. therapist) environment. Another distinction between the Mental Health Clubhouses approach (Agner et al., 2020) and the therapeutic form of Ijambo, is that the former is explicit about "mental health" while the latter can be about people conversing in any type of conversation that may talk about mental health but implicitly. Conversations through Ijambo are not assumed to target the betterment of "mental health" but the improvement of social life through community care.

Regardless of a participant's role in Ijambo, the dynamics may be interpreted as "I know that you too have suffered, and it can be fair and humanizing for you to listen to my shame, humiliations, and to see my tears only if you can reciprocate." This study confirms the assertion of collective struggle that suggests the need to collectively acknowledge the harm inflicted on the people as a group (Petersen-Coleman & Swaroop, 2011). Therefore, in Ijambo, there is no "listener," credible "helper," or "storyteller" and "one helped." All participants including the facilitator are in the community and alternate playing

all these roles moving back and forth. In this framework, being vulnerable is not equated with individual weaknesses or abnormalities. It is rather an opportunity to distinguish the brain-body responses to abnormal experiences from individual failures (Haines, 2019) and to encourage social responsibility in addressing individual problems. When everyone in the space is open to sharing not just how they were impacted, but also what strategies and resources they have used to sustain life, the space can be affirming and empowering (Bangura, 2011; Ndagijimana, 2019). Further, given how much the people were able to share, the findings contradict the understanding that Rwandans are culturally stoic (Eramian & Denov, 2018).

The strengths that stem from collective vulnerability seem to reveal the blind spot of the common "*ubuhamya*" (testimony) style of listening to stories of horrors where one individual is invited on *a stage* to speak on a "personal" trajectory of trauma while others are "listening." This can be overwhelming and retraumatizing. By contrast, when participants observe relatable survival patterns in Ijambo (the sacred time to share stories and perspectives) in a space where each participant is a listener and a storyteller, it seems to help them "read" the world in a way that they individually and collectively look back with self and collective rehumanizing lenses. The plurality of stories may tell individuals that they are not alone and that what they go through in privacy is common and it is not that they are morally bad people (Haines, 2019). Previous studies (Denborough & Uwihoreye, 2019; Nyiransekuye, 2011) support this claim. The creation of such environments is especially important in Rwanda where, for various reasons, concealing emotional vulnerabilities is understood as the norm (Mukamana & Brysiewicz, 2008; Mukangendo, 2007). Findings suggest that collective storytelling and identifying shared patterns have the potential to help individuals realizing that their suffering is not a sign of weakness. When the stories congregate, people may start to realize that they are not actually "weak," but resilient wellness warriors with heroic stories of endurance. In this context of Ijambo (the sacred time to share stories and perspectives), one responds to someone's else's story—not to accumulate damages, deficits, and vulnerability, but to transmit strength that comes from the perceived "sameness," hope, and learned practical coping tips.

The findings also suggest that in the culture and context of Rwanda, a therapeutic trust may not be built by just how much the helper "listens," but also how much they are willing to open up, share their positionalities, and model the openness they want to see from those they intend to support (Ndagijimana, 2019). In this "equalizing" relationship, the Rwandan "client" needs to feel that there is no "therapist" or "client" in the room, but humans whose wellness depends on the other's wellness. A therapist needs to act not just as a therapist but as a human, a friend, a caring neighbor, and be comfortable sharing his or her own vulnerabilities as they relate to the issue being discussed. In that relationship, those in the "therapist" roles need to play a participant-observer role (Green, 2014), remaining mindful about how and when they alternate between the two roles both as a therapist and a client.

Moreover, while project partners discussed topics that could be understood as mental health-related, they never mentioned the word "mental health" and when "counseling" was mentioned they said it was not for them. The situation matches the findings in the study Nyiransekuye (2011) conducted where participants engaged in therapeutic activities without calling it "therapy." In the same spirit, the project partners did not explicitly admitted they suffer from any "mental health" issue. Instead, they collectively agreed that some of them could be compared to "rotten potatoes". They explained that they associated some of their peers as rotten potatoes mostly because of the unhealthy habits they present.

It may not be a coincidence that the project partners used the word "potatoes" to refer to the umbrella of the symptoms some of them present. It would be important to recognize that majority of them (18 of the 23) are from farming families and the school is in a rural area and in a district where potatoes are the most common crops. The "rotten" potatoes did not just give them the lenses through which they interpret their social world, it did also inspire them to think of the coping mechanisms they needed to support the group members struggling. This suggests that the environment where people live give them the tools to view and interpret their social world. The choice of words such as "potatoes" and "feeling stuck" also seem to indicate that within this community and possibly in many other cultures and especially in Africa (Poxon, 2013), metaphors seem to offer convenient language for the people to name their social world and what they desire to improve their situations. This indicates how much language matters in mental health. For instance, the findings suggest that while the project partners did not want to associate themselves with the concept of "mental health," they admitted that some of them "feel stuck in depression" and some expressions of the distress were likened to "rotten potatoes," expressions, which could be understood as "mental health" issues in cultures that use the latter concept.

In the same spirit, the findings indicate that the word "counseling" is directly associated with mental health issues, and consequently, the former is as stigmatized as the latter. It was also interesting to observe that the project partners suggested to keep what is expected from a "counseling" session such as what they called "kwividura" (pouring out) heavy emotions but preferred that the word "counseling" be replaced by "ubufashamyumvire" (awareness facilitation), which implies "training one another." Therefore, findings show that it was not that they did not feel to need counseling, instead they did not want the potential consequences from associating themselves with it. They, therefore, generated their concepts and frameworks that seem to offer a pathway to walk around stigma and get the support they need.

Moreover, by agreeing that the process of the study played a therapeutic role, the post-genocide youth-led GT

of psychosocial recovery suggests a need for a research framework that need to center "researching as healing and healing as researching." This recommendation supports Rodriguez and Kuntz's (2021) suggestion to transform data collection processes, especially in trauma-affected communities into healing events.

Another finding that is worth particular attention are the concepts born from the community's theorization. In a way that seems to invite professionals in mental health in Rwanda to be more cautious about how they name psychological issues, the concept of guheranwa n'agahinda (feeling stuck in depression) is the only mental health-related syndrome the project partners named in addition to guhangayika (stress). For the community, the latter is not a syndrome as the former but a way of life especially when not prolonged to make one feel stuck. In their study, Betancourt et al. (2011) identified some local mental health syndromes that include guhangayika (stress) but did not speak about guheranwa n'agahinda (feeling stuck in depression) as a mental health syndrome. Some of the symptoms of feeling stuck in depression that the project partners in this study named were also reported in Munyandamutsa et al.'s (2012) nationwide study that reported both mental and somatic symptoms in PTSD patients. Other symptoms of the feeling stuck in depression syndrome, such as social mistrust, avoiding connecting with others, loneliness, and not having anyone to tell were also found in the study by Mukamana and Brysiewicz (2008).

Probably the most important symptom of those feeling stuck and which previous studies on local mental health syndromes (Betancourt et al., 2011; Munyandamutsa et al., 2012) had not named is the choice of to whom those who are suffering would or would not want to tell their story. For the project partners, people who are feeling stuck in depression fear seeking support and are likely to reject advice from anyone that does not share their lived experiences. This assertion is in line with findings from Nyiransekuye (2011) who suggests that some community members feel safer narrating their stories of harm with those who share similar past experiences and current vulnerabilities. This study, therefore, contradicts the notion that because of local social mistrust, foreigners are in a better position to heal psychological wounds in post-genocide Rwanda (Leach, 2015).

It can be true that some people may hesitate to share their vulnerabilities, especially to those they associate with the source of harm they suffer (Petersen-Coleman & Swaroop, 2011). With such a community whose social trust was betrayed by the genocide (Abiosseh et al., 2019), some may also not trust the level of confidentiality regardless of who the "therapist" is especially when the helper is local and may share personal connections with one seeking support. There is fear that somehow the secrets will be shared with the public and be used against the sufferer. The complexities should not be viewed as an invitation to decenter the local agency (Downs, 2016) but a call to build social trust (Abiosseh et al., 2019). This does also not suggest that foreigners should not participate in the country's healing journey, but their involvement may require different skills and resources than they assumed were necessary. It suggests a need for being more curious to learn from local epistemologies and support community-led initiatives that result from the people's collective ways of knowing.

In post-genocide Rwanda, inconceivable experiences have forced people to theorize from the margin of the academic discourse to name their realities. While the word *"agahinda"* (depression) existed before the atrocities, guheranwa n'agahinda (feeling stuck in depression) became a thread in the aftermath. The concept and others that are emerging from the direct experiences have never made it into classrooms and scholarly papers. For the people, however, these epistemologies are pertinent. They instill a sense of urgency, ownership, and collective accountability (Downs, 2016; Nyiransekuye, 2011).

The concepts of kongera kwiyubaka (rebuilding ourselves again), guharanira kwigira (striving for self-reliance), and kwishakamo ibisubizo (finding solutions from within) constitute some other major findings. Rebuilding ourselves again suggests that the people of Rwanda were destroyed by the past experiences, and in the post-genocide, they are striving for "living again." In that case, "rebuilding ourselves again" denotes a post-genocide recovery process. However, "recovering" from the genocide is complicated and what it seems to require push the boundaries of what we have commonly known as tools and mechanisms for trauma healing. Findings from this GA of post-genocide young community-led healing framework suggest that individual's and community recovery require guharanira kwigira (striving for self-reliance). In this context, however, "self-reliance" is about mutuality. Explaining "*why guharanira kwigira is a winning mantra*" in Rwanda, Kebongo (2013), suggests that self-reliance in this context "does not imply isolationism. It is engaging more in a give-and-take manner" (para. 13). This form of asset-based and mutuality is mostly seen in the Rwandans' collective efforts to earn some basic incomes mostly through cooperatives and informal savings and credits (King et al., 2017). Coming together to take care of rabbits offers a space for organic and spontaneous social support, which seems to respond to the issue of social isolation that Mukamana and Brysiewicz (2008) discussed. Moreover, by developing a rabbit project as a therapeutic space, our findings support an emerging framework that suggests combining livelihood and psychosocial initiatives (or livelihood informed psychosocial mechanisms) in economically vulnerable communities with trauma experiences (Schinina et al., 2016). This framework goes beyond the "historical trauma" that Gone et al. (2019) discussed to recognize and center daily struggles that may or may not be associated with multigenerational trauma. The younger generation's wider healing framework, targeting both the stress and its source (or what my project partners call "kwica gitera"), reflects the post-genocide government's spirit for "self-reliance," rebuilding ourselves again, physically, socially, emotionally, and economically.

In this context, the mental and physical health needs are not to be separated but addressed together (Munyandamutsa et al., 2012; Nyiransekuye, 2011).

It is also important to note that while the project partners were comfortable creating the safe and brave space (Arao & Clemens, 2013) and defined the problem in my presence, when the time came to frame solutions, they preferred to exclude me from the conversation. This suggests that the prior process of defining the problem socialized them to feel that they have the power to control whom to invite and leave out when theorizing solutions and strategies. The results also exemplify their ability to kwishakamo ibisubizo (find solutions from within) when given the space and opportunity to have full control of what they end up deciding. The finding also suggests that while "diagnosing" a community problem may engage different players, deciding what to do about it needs to be the privilege of those who are meant to benefit from the service. The spirit matches with Downs (2016) calls for African urgency in healing psychological wounds in the Eastern Congo. By engaging community members as experts in their own healing process, Indigenous and community psychology offer unique opportunities to center people's values and cultures in an anticolonial fashion (Gone et al., 2020).

CONCLUSION

This GA research study intended to generate a Rwandan post-genocide youth community-led healing framework by engaging high school students with their lived experiences in theorizing the "problem," generating actions that are rooted in the needs of the realities of their lives and evaluating the efforts. The study showed that given the context of Rwanda, its history, living conditions, and local culture, the meaning of healing is local and Indigenous, and this has significant implications for helping people overcome the trauma of genocide and beyond. Mostly with the community members who are economically vulnerable, the concept of "psychological healing" as a stand-alone concept is both narrow, inconsiderate, and detached from the realities of the people. This study reveals that the community-led psychological healing framework in post-genocide Rwanda is within the concept of kongera kwiyubaka (rebuilding ourselves again), a word that ties up Rwandans' spirit, making the individual and national recovery almost synonymous.

The kongera kwiyubaka (rebuilding ourselves again) framework suggests what to do, what to avoid in the recovery process and provides some iterative stages. For the recovery to take place, it suggests starting from gusasa inzobe (openness to share what is in our hearts), a process that is suggested to be encouraged but not forced. When that is secured, it helps prevent silently violent conflicts that could explode when it is no longer possible kurenzaho (to pretend there are no conflicts and pains). This in turn builds social trust, which in return lead to kwigira (collective self-reliance) and mutuality. Therefore, while successful collective self-reliance may result from a complexity of factors happening more simultaneously than linearly, there is value in understanding the theory in chronological order.

The stages may range from establishing ways to address existing, anticipated, or assumed conflicts, creating convenient spaces for the people to be vulnerable with each other, which also build social trust and friendship. And whether initially intended or not, when the first steps are successful, collective income-generating initiatives are often results that can be anticipated. This understanding can be viewed through the common cooperatives, informal savings, and credits in Rwanda. Without the income-generating component, the psychological healing framework could be visualized as a building without a roof, a feeling in "psychological healing" spaces with economically vulnerable people where "side walls" (counseling) may not prevent "clients" from getting wet (emotional pain) from the rain (stressors). In this iterative process, as a new step sinks, it cements the preceding step, making the stages more fluid and permeable than linear.

Following the increased rate of mental health-related issues in Rwanda post-genocide together with the reluctancy of the people to seek the Eurocentric frameworks of mental health services, this study engaged youth from a Rwandan high school to play the role of the expert in theorizing their needs and designing the interventions they would feel comfortable seeking. The data that informed this youth-led GT of post-genocide psychosocial recovery framework grew out of an iterative process that involved five steps, including (a) diagnosis or delving into their individual and shared struggles, (b) action planning, (c) action taking, (d) evaluation, and (e) specifying learning. The theory generated indicates that for this community, (1) a more culturally and contextually relevant framework of psychosocial intervention needs to be collective in its nature, building relationships and addressing real and assumed genocide-induced conflicts as the foundation for the people to join their efforts and address their individual and collective needs. (2) The theory also suggests that once social trust has been established, the service users (community) are to define how their individual and collective experiences impact their lives. (3) The framework shows that when the two first stages are successful, they empower, inspire, and motivate a community to find solutions from within. This study indicates that adequate healing in this context and culture needs to be holistic, it must be a multidomain concern about peoples' lives that far exceeds what any therapeutic-only mental health effort by itself could provide. To create such culturally and contextually relevant frameworks, this study indicates that taking up Indigenous livelihood informed psychosocial solutions and centering community-led approaches is essential. The process we centered on is one of the approaches.

CONFLICT OF INTEREST

The author declares that there are no conflict of interests.

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