Care as a turning point in sociotherapy:

Remaking the moral world in post-genocide Rwanda

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Community-based sociotherapy was introduced in Rwanda in 2005 in order to contribute to the healing of social worlds that were severely damaged by war and genocide. People who participate in sociotherapy perceive this intervention as medicine for their troubled hearts. Each sociotherapy group, averaging twelve people, holds fifteen weekly meetings. Two facilitators guide the group through six different phases: safety, trust, care, respect, new rules, and memory. It is mostly during the care phase that a substantial part of the participants experience a change in their lives, which is the beginning of the reparation of their morally shattered social world and, subsequently, the reconstruction of social capital in its entirety. The analysis of this process is based on qualitative research about the practice of sociotherapy and its impact on the communities where it is practiced.

[Rwanda, genocide, social disconnection, sociotherapy, moral world, care]

Rwanda has suffered through large-scale political violence in its recent past. One of the devastating effects of this violence is the severe erosion of social capital. The key element of the concept of social capital is that 'relationships matter' (Field 2003). What many people in Rwanda are suffering from is the destruction of social relationships. As Jackson (2002: 39) observes: "Because violence […] occurs in the contested space of intersubjectivity, its most devastating effects are not on individuals *per se* but on the fields of interrelationships that constitute their life-worlds." Therefore, in the aftermath of the massive trauma Rwanda experienced, one of the major challenges is the re-invention of shattered social worlds. Particularly in places where people have to live together in conditions of close proximity and depend on each other in day-to-day life, a renewed form of social cohesion and the reconstruction of social capital in its entirety are required.

In most social capital studies a distinction is made between bonding and bridging social capital and within each of these two types between structural and cognitive social capital. Bonding social capital refers to relationships between individuals within a specific social group whereas bridging social capital refers to relationships

across different groups in a society that do not necessarily share similar social identities. Linking social capital is a specific form of bridging social capital that applies to 'vertical' interactions across explicit, formal, and institutionalised power or authority structures in society. Structural and cognitive social capital both operate at micro (individual person or family) levels and meso (neighbourhood, community, formal or informal group) levels of society. The structural form of social capital available in a particular society comprises the extent and intensity of social links or activity, and the cognitive form covers the perceptions of support, reciprocity, sharing, and trust (Almedon 2005; Colletta & Cullen 2000; Poortinga 2006).

In this article we examine the erosion of social capital that is a result of the rapid socio-cultural change generated by the political violence of war (1990-1994) and genocide (1994) in two regions of Rwanda – Byumba and Nyamata – as well as the recreation of social capital in both regions through the mediation of community-based sociotherapy, an intervention program that started to function in these two regions in respectively 2005 and 2008. In particular, we will explore how an increase in cognitive social capital in the form of safety and trust builds the foundation for the development of social links and activities of which care is the central component. The care that evolves contributes to bonding as well as bridging social capital.

Our exploration is based on ongoing qualitative research about the practice of sociotherapy in the field and its impact on participants in the program and their social environment. Our main research methods were: (participant) observation, reports by facilitators of group sessions, case studies, formal and informal interviews, focus group discussions, home visits, and 'most significant change stories' collected and selected by facilitators. The main participants in this research were: sociotherapy group (ex-)participants (as well as their families, friends and neighbours), group facilitators, sociotherapy program staff, and local authorities. Cora Dekker also added her experiences as an expatriate trainer in the programs.

The political violence in Rwanda and its legacies: Byumba and Nyamata

The recent political violence in Rwanda has taken different forms and affected people and communities across the country in different ways. These differences have implications for the practice and impact of sociotherapy. Going into the complex history of violence and repression that led to the war and genocide is beyond the scope of this article.[1] We merely point out some different experiences with the political violence of the recent past and its aftermath in the two regions where sociotherapy programs are functioning: Byumba town and the surrounding area, which together comprise the area designated until 2006 as Byumba province (Byumba hereafter), and Nyamata town and the surrounding villages in the south-east of the country (Nyamata hereafter), situated in Bugesera district.

People in Byumba and Nyamata have experienced many similar traumatic events, but there are also differences in the nature and degree of trauma and suffering within and between the two regions. Byumba suffered in particular from the civil war which

was primarily fought in the north of the country. Low-intensity fighting between a Tutsi dominated army – the Rwandan Patriotic Front (RPF) – and a Hutu dominated army – Forces Armées Rwandaises (FAR) (Armed Forces of Rwanda) supported by paramilitary forces (Interahamwe) was punctuated by several massacres. In addition, looting and destruction of property took place on a large scale. People in Byumba were mainly abused by soldiers unknown to them. However, neighbours also harmed neighbours in one way or another. The unrest led to a massive displacement of people – Hutu as well as Tutsi – to refugee camps and other places of shelter further south and in adjacent countries. The experiences of those who were displaced within the country or exiled abroad were often also quite traumatic. Exile was simply the continuation of war by other means. The camps were highly militarized and the living conditions in and around the camps were very harsh. This resulted in thousands of people dying of hunger, disease, and violence. Those who returned home had to try to rebuild their lives in a socially and materially devastated environment.

The north of Rwanda was mainly inhabited by Hutu, the majority of whom had already been displaced when the genocide began. This explains why the killings during the genocide, which were mostly directed at Tutsi, were not as frequent in Byumba as in many other parts of Rwanda. In Nyamata the Tutsi outnumbered the Hutu in the period preceding the genocide. The beginning of the civil war in 1990 marked the resurgence of hatred and killings of the Tutsi, particularly in Nyamata, which eventually became the epicentre of the genocide. It is estimated that less than 3% of the Tutsi population survived. Many of them are the sole survivors of their family. From Nyamata many Hutu, accompanied by some Tutsi, fled in contrast to Byumba only during and immediately after the genocide to neighbouring countries. Most of them suffered there, similar to the exiled population from Byumba, from degrading living conditions. The majority of those who survived returned to Rwanda, including Nyamata, sooner or later. After the genocide the Tutsi who were exiled from 1959 onwards also returned to Nyamata, which increased the Tutsi population in this region again. Meanwhile, throughout Rwanda, revenge killings of the Hutu population continued to happen in the immediate aftermath of the genocide.

Until today many people in Rwanda are suffering from their war and genocide experiences. In addition to their various losses and traumatic memories, they are troubled by poverty and issues related to the impact of the justice system on their everyday lives. For some people these latter issues have been more traumatizing than the preceding political violence, for others these issues were an additional source of trauma. Four years after the war and genocide had ended there were approximately 135,000 prisoners in Rwanda, mainly Hutu, who were locked up in overcrowded prisons. It was impossible for the damaged justice system to handle such a large quantity of cases. Therefore, in 2001, *gacaca* (a community-based method of administering justice) was launched. Since 2003, Rwanda has released between 50,000 and 60,000 prisoners (mainly by presidential decrees). About 80 percent of these prisoners were accused of involvement in the genocide. Hundreds have been re-arrested, mainly following their appearance before *gacaca* courts; some of them after committing other crimes, including killing genocide survivors in a bid to destroy evidence, others after

new, sometimes forged accusations. The weight of their (alleged) crimes is not only felt by these individuals, but by their families as well (see below).

The regional differences between the political violence and its aftermath in Byumba and Nyamata, in addition to differences in culture, socio-economic developments and local political context, impact not only the variety and kind of issues people suffer from but also the issues that people choose to avoid or bring forward for discussion in the social spaces created by sociotherapy. In the sociotherapy program of Nyamata ethnicity-related issues, for instance, are more prominent and also more openly spoken about than in the program in Byumba. However, despite the fact that people's suffering cannot be equated or regarded as similar in every aspect, many people who are severely traumatized consider the 'loss of their humanity' as the core of their suffering.

Deficiencies in quantity and quality of care

The situation in Rwanda was in 2004 described by Pastor Emmanuel Ngendahayo, who the subsequent year (2005) became the coordinator of the Byumba sociotherapy program, as follows: "There is a general feeling of insecurity, powerlessness and desperation among the population. Many people do not care about themselves anymore. People have lost their interest in dignity and do not care about the future. Some have become aggressive in reaction to just anything, whether good or bad. Others are aimlessly wandering around without courage or a plan to survive." Two years later, women participating in a sociotherapy group in Byumba identified the following problems in society as a result of the trouble Rwanda had experienced: an epidemic of loss of lives, individualism and egoism, a lot of hatred, jealousy and mistrust among family members and neighbours, and a variety of conflicts and frequent cases of poisoning as a reaction to the past experiences. While Pastor Emmanuel refers in particular to individual psychological problems and their social consequences, the women emphasize more relational issues, which boil down to the loss of social connectedness as a moral force that makes people take responsibility to care for others. For the many people who are in urgent need of care, it is not adequately available or not available at all.

While many Rwandans experienced "the complete sundering of the empathic human dyad" (Laub 2002: 66), the ability to sympathize and care can still be found in families, communities and society at large in the post-genocide period. The problem is that it has been far from sufficient to meet the needs of the large proportion of vulnerable people in Rwandan society. Furthermore, the formal and informal forms of care that withstood the period of turbulence did not, in many situations, recognize the specific needs for care within families and communities. Types of care are needed that were uncommon in former days, such as responding appropriately to the sorrow of genocide survivors, verbally sympathizing with and visiting women and children whose family members are imprisoned or involved in the judicial process, and showing concern for the well-being of prisoners and ex-prisoners. On top of all this, many people who are providing the formal and informal care are also suffering, as they were

also traumatized by experiences of extreme violence, from "ruptures in the fabric of their identity" (Laub 2006: 65). The basic structure of their self is damaged in the sense that they have lost the ability to maintain their own separate point of view while remaining in connection with others (Herman 1992: 51-74).

The goal and method of community-based sociotherapy[2]

The goal of sociotherapy in Rwanda is to help people – trainee-sociotherapists as well as sociotherapy participants – regain feelings of dignity and safety and reduce mental and social distress. When sociotherapy started in Nyamata in 2008 reconciliation between people of different ethnicities was singled out as a specific sub-goal that needed particular attention.

Sociotherapy helps to rekindle the potential for care that is still available within people and communities and adapt it, when appropriate, to situations where specific kinds of care are needed. The adjective 'community-based' refers to the fact that the two sociotherapy programs in Rwanda are each based in a geographically defined set of 'communities', such as communities of people living in the same place (e.g. neighbourhoods) or working, studying or worshipping in particular places and institutions (e.g. a school or a church). 'Community' defined as a value (e.g. meaningful relationships between people and well-functioning supportive social networks) can be considered a potential successful outcome of the program. As we described above, in Rwanda communities conceptualised as valued social worlds were shattered due to war and genocide and thus need to be re-created.

Sociotherapy is carried out in small groups of usually ten to twelve people. The groups meet in a variety of physical locations where people generally feel at ease. This can be a classroom in a school, a church, someone's house, benches under a tree, or in an open field. During fifteen weekly group sessions of a few hours, group participants are guided in their participation by two facilitators through a process consisting of six phases: safety, trust, care, respect, new rules, and memory. Throughout these six phases the following six principles are applied: interest, equality, democracy, participation, responsibility, and learning-by-doing by using current situations. "Both, phases and principles, encourage everyone to take care of each other in order to reduce or resolve each other's problems" (sociotherapist). It is the dynamic complexity of principles and phases as a whole that makes sociotherapy work the way it does. However, sociotherapists consider the first two phases – safety and trust – as the backbone of sociotherapy. All six phases are presented visually for the group on either a blackboard or a flipchart, or simply drawn with a stick in the earth as part of a circle, divided in six parts. The circle (*uruziga*) is presented to participants as 'the journey' they embark on in the program of sociotherapy.

The principle of interest can be seen as underlying all other principles. It is also the principle most directly related to care. Interest is a concept derived by Cora Dekker from the concept of *inter-est* as defined by the philosopher Hannah Arendt (1958). Arendt (1958: 182-183) distinguishes between two meanings of this concept. People's

specific, objective, worldly interests "constitute in the word's most literal significance, something which *inter-est*, which lies between people and therefore can relate and bind them together. Most action and speech is concerned with this in-between, which varies with each group of people (…)." This first "physical, worldly in-between along with its interests is overlaid, as it were, overgrown with an altogether different in-between which consists of deeds and words and owes its origin exclusively to men's acting and speaking directly to one another." Arendt refers to this second, subjective in-between reality as 'the web of human relationships'. The metaphor indicates its somewhat intangible quality. People in Rwanda experience the collapse of the *inter-est* in its second meaning, the collapse of the web of the social relations they belonged to in the past, as social death. According to Arendt (ibid: 176), a "life without speech and without action is literally dead to the world; it has ceased to be a human life because it is no longer lived among men." In Rwanda one would say that that life is a life without humanity (*ubumuntu*).

Dekker explained the principle of *inter-est* in her training (presented to the trainees as interest) by saying that people who are interested in each other may raise questions like: "how are you," "what do you mean," how do you do things'," "how do you see things," "how do you experience things." This is how a dialogue starts. Some sociotherapists told us in a focus group discussion that they explain the principle to participants as the first step towards caring for someone (*kwita k'umuntu*). "Showing someone that you care is to first show an interest in him or her. When you start asking the question of 'how are you', you show that you care about the person you address." Another sociotherapist added: "Everyone in the sociotherapy group has to take the problem of another member into account, even if it displeases him. In fact, he (a group member) takes it as his own. This makes him give a piece of advice while placing himself in the position of the other."

In the same group discussion, sociotherapists also pointed to the effects of a lack of interest. "Disregard for another person may lead to loss of life, a woman hanging herself because she feels humiliated. Children may become street boys and girls, because they feel uncared for or disliked" (sociotherapist). Another sociotherapist stated: "If the principle of interest is not put into practice, serious conflicts can be the result. Interest refers to the fact that people need each other, because everyone needs another person to survive." For him, the principle is succinctly expressed in the Rwandan proverb *Inkingi imwe ntigera inzu* (One pillar cannot make a house).

The principle of equality, according to sociotherapists, refers to respect for each other and the equal opportunity for everyone in the group to express his or her ideas. No one should be prevented from doing that. One way of working towards a feeling of equality is sitting in a circle during the sociotherapy group sessions. In order to guarantee that equality and democracy are put into practice (action speaks louder than words), the group members decide together which rules will guide their group and how the group will function. Also, in other activities participants learn and experience that everyone's opinion has equal value. The dynamic in the groups provides many moments for participants to learn from. Group members are supposed to take responsibility for what they contribute in the group. Through, for instance, leading their own

communication without interference of the facilitator, participants gradually start to feel responsible for each other and act accordingly. In order to create and maintain a spirit of peace and safety in the group, it makes sense to keep the focus on the present. If people solve problems in the present, they may be able to think about the future again. Feeling better in daily life also creates better conditions for processing the past.

Sociotherapy as 'medicine'

The term sociotherapy may suggest a medicalizing approach to social problems. The point of sociotherapy, however, is that its therapeutic value comes from the active input of the group members as they participate, question, advice, influence and correct each other in their social contact. One woman who is a widow infected with HIV/AIDS and suffering from weakness, hopelessness, social isolation, fear of death, and stigmatization, said in an interview: "Nurses cure the body, but sociotherapy cures the illnesses of the heart." Another widow said about the effect of sociotherapy: "It was like vomiting; everything in my heart came out." Because of the connotations the term 'therapy' may conjure up, a more appropriate term may be advisable. However, the name sociotherapy (*sosiyoterapi* in Kinyarwanda) soon became a well known concept in Rwanda, which makes it difficult to replace it by other Kinyarwanda concepts that are being used to refer to what people consider to be the core of sociotherapy, but which do not cover all aspects of this intervention. The same can be said about the concept of sociotherapist.

When sociotherapy is labelled by group participants as 'medicine', as is regularly done, the term is used as a metaphor for something that works quickly and effectively. Most of them realize that it is the corrective power of the sociotherapy group that makes the intervention work. Sociotherapy is indeed first of all directed at the social level and not at the psychophysiology of a person. People, however, also notice changes as a result of sociotherapy on a psychological and physical level. Like Veronique, who testified: "I tell you at that time [when she joined sociotherapy] I weighed 43 kilo, but now I weigh 65 kilo. Why? I did not eat more food than before; there is nothing else I can say, nothing but peace, peace in my heart. Where did I get that peace from? In sociotherapy."[3]

Facilitators also label sociotherapy as 'medicine'. After the initial excitement about the positive impact of sociotherapy, however, facilitators have become more cautious and nuanced in their evaluation of the effect of sociotherapy. The most recent (April 2010) evaluation by a selection of sociotherapists of the effects of sociotherapy is that it is very effective as 'medicine' for 60-80 percent of participants. One of the reasons for the lack of a positive impact is that people may not want to participate in a group at all or stop participating because sociotherapy does not provide any material support in the form of, for instance, food, incentives or shelter, which almost all other governmental or nongovernmental psychosocial support and training programs provide. Another reason may be that people refuse 'to open up' and do not speak at all or 'lie'. At the end of the program some participants have more fear, less trust in others or are

more saddened by their life conditions. Participants may also be very unhappy that the group sessions stop after 15 weeks, just when they are starting to feel at ease. The estimation in Byumba is that 20 percent of ex-participants choose to join a second group because they are not satisfied with the results of the first one.

One of the leading sociotherapists expressed the following view to his colleagues while rehearsing what they had learned about sociotherapy: "Sociotherapy is like a teacher and a medicine. You (as a sociotherapist) have to prepare it well and they have to take it well." Apparently some people 'do not take it well'. On the other hand, sociotherapists often feel incapable to 'prepare and deliver it well' which leads to frustration among them. One of the frustrations is that "even if participants do not ask for material means, as facilitator you feel something is missing" (sociotherapist). Another frustration is the lack of enough follow-up training. As one experienced sociotherapists said: "We need training to extract the truth; truth especially of those who have heavy things on their mind." This 'extracting of truth' must be difficult, for example, in case of those ex-prisoners who "feel like they have forgotten what they did" (sociotherapist). Laub (2002) writes about Holocaust perpetrators as people who do everything to protect their self-image and never reconnect with the truth of their lives. She refers to perpetrators' strategies to evade the truth as equivalent to the psychoanalytic term 'screen memory', which shields the perpetrator from a search for truth (69-70). However, also victims will have experiences too terrible to reveal and thus shield away from the truth ('the unspeakable').

Dignity and care

While sociotherapists argue that everyone in Rwanda is in need of the care sociotherapy can offer, they nevertheless identify categories of people who are particularly vulnerable and therefore more in need of care than others. These categories include widows, orphans, single mothers, genocide survivors, ex-prisoners, women with husbands in prison, people living with HIV/AIDS, and elderly men. They all suffer from feelings of loss of human dignity, partly due to societal stigmatization. Dignity, from the perspective of sociotherapists and (ex-)participants, refers to worthiness or being valued (*agaciro*), having value as a human being (*ubumuntu*), having a good image or reputation (*kugira ubuhamya, bwiza/kuboneka neza*), being blameless (*ubuziranenge*) and being a person of integrity (*ubunyangamugayo*).

Sociotherapists from Byumba in a group discussion focusing on dignity differentiated between four categories of people who are likely to suffer from a loss of dignity: widows, orphans, single mothers and ex-prisoners. In Nyamata women with husbands in prison were singled out as another category susceptible to dignity loss.

Dignity for widows means being cared for. Many widows suffer from being neglected, disrespected, and mistrusted. They often feel too ashamed to go out and suffer from isolation. A widow will say: "A widow is a widow and it is all over, it is like we are finished". The home of a widow is per definition 'invaded', meaning that there is no one to protect her. She is alone with a vacuum around her. She generally

feels voiceless and powerlessness (*nta jambo*). This is made even worse when the family-in-law sends her away, saying that she is not worth anything anymore. Receiving care helps to change this situation. As a widow told us, "So and so did this to me and it made me feel like others." This widow feels recognized as a human being through being cared for.

Dignity for an orphan is also being cared for. An orphan feels great sorrow due to lack of love. Rwandans say *umwna wundi abishya inkonda* (a child of another is difficult to love). Even if orphans have found a new home with caring foster parents they feel emotionally discriminated. "If I was his child, I would not have hugged him that way, I could have run and clung on his neck", is what an orphan will say. If they are treated poorly by a foster parent they say: "It is because I am not their child", even if the parents' own children are treated poorly just as much. A double orphan (a child who has lost both parents), even if well educated with a good job and a good salary, may have no relatives (uncles) willing to sign for her at the Sector office to have her marriage officially recognized. She is left alone with this problem to solve. What sociotherapists observed is confirmed by the results of a large survey among youth heads of households (Thurman et al. 2008). Those results reveal that many orphans in Rwanda believe that 'no one cares about them' and that they feel rejected by the community. Social isolation appears to heighten their vulnerability to abuse and exploitation and leads to feelings of despair, and even suicidal thoughts for some.

Single mothers are mothers who have sole responsibility for their children. These women include widows, divorced women and women who have never been married. To the last category belong girls who gave birth at their parents' house. Such mothers are seen as a plague in contemporary Rwandan society. Being a single mother like them is considered a sin. They are cursed, and when they pass by people point their fingers at them. No wonder these girls suffer from a loss of self-dignity and dignity in the eyes of others. They feel ashamed and humiliated and always walk with her head down. These girls have to fend for themselves and have no one to care for them and help them care for their children.

For ex-prisoners, dignity means to be freed from the shame and humiliation that burdens them after their release. The value and respect they had in society before their imprisonment is lost when they come out of prison. "For people out there it is simple, when they see prisoners in their famous pink outfits,[4] only one thing goes through their minds *bariya ni abicanyi* (those are killers)" (ex-prisoner). It seems that that label follows them even after their release, because "when people hear that so and so was in prison, it is always concluded that 'he is a killer', with no effort made to find out the reason why he was imprisoned in the first place" (ex-prisoner). When an ex-prisoner is released because he proved to be innocent, he still feels shame. For ex-prisoners (including those imprisoned because of common crimes and those who proved to be innocent) the meaning of dignity is to be accepted into society again.

What the loss of dignity means for women whose husbands are in prison is best expressed by Estelle: "Personally the first thing I am thankful for is that sociotherapy brought me back to Rwandan society because I had left it and become like an animal. I was no longer a human being." Those women feel that they are worse off than widows

because they have an extra burden to carry, the stigmatization of being 'the wife of a killer' and having to take care of their husbands in prison.

Care for all of these people means social recognition and as a consequence social reconnection in the practices of day-to-day life. In most cases, it is during the phase of care that sociotherapy group members start to visit each other (see below). They begin making new and meaningful relationships with neighbours. Some start reading the bible again, revisit the Church or invest more in studies. Others stay away from the church in order to avoid confrontation with painful memories. We can consider these strategies as self-recognition and self-care. "I was a child of God and I am going to restore that situation." If that situation is indeed restored, the feeling of worthlessness is likely to stop too. Participants or ex-participants may also build a house together for one of the members.

Particularly in Nyamata sociotherapists have experienced many cases where genocide survivors and ex-prisoners start to relate to each other and care for each other. One is the case of Immaculee, a genocide survivor. She participated in a sociotherapy group with ex-prisoners among its participants. Alphonse is one of those ex-prisoners. When Immaculee's son got admitted to the hospital, all group members – including Alphonse, the president of the income-generating association which the group had started – made contributions so that she could travel to the hospital. Immaculee quite clearly said that the group stood by her in that difficult time. This is how she describes being in a group with ex-prisoners: "Actually we are not afraid of joining those (ex-prisoners) with whom we shared these dialogues of sociotherapy as we have already become one. You can call on him (Alphonse) when you have a problem and he would be the first to come to your rescue."

Care as a turning point in sociotherapy

Care has many faces. The people who initiated the sociotherapy program expressed care by thinking of creating such a program. Putting the program into practice expressed again care for people around them, whom they had not yet been able to help. The sociotherapists were cared for during their training and started also to care for fellow-trainees. Sociotherapy group participants went through a similar process of care; a process that started with being cared for (*kwitabwaho*) by sociotherapists to self care (*kwiyitaho*) and care for one another (*kwitanaho*). "Some people start already feeling cared for when a sociotherapist visits them at home and invites them to participate in a sociotherapy group; and when a sociotherapist asks during the first session, 'how do you feel', care is already experienced in their body" (sociotherapist). "For others, being invited means trouble, and they ask themselves, 'What do they want from me'? 'What have I done'? However, when they do come and return for a second session, many have found a ground" (sociotherapist). It is during the phase of care that the one-sided longing for being taken care of (*kwitabwaho*) is in most cases being replaced by the realization that others equally need care and that care should be reciprocated (*kwitanaho*). Care means for sociotherapists and participants alike first

of all valuing a person as a human being (see above). In practice it means listening to other people and giving them time and space to tell their story; as a sociotherapy group of orphans sang in a public ceremony "I hear you, you hear me." Secondly it means advising other people, and lastly doing something tangible for them.

Dekker explored what happens in the phase of care with sociotherapists-in-training in Rwanda as well as South Kivu, DRC (where a third sociotherapy program is operation since 2007), based on their experiences with the practice of sociotherapy in the field. The trainees reported that in order to re-establish safety and trust, most of the sociotherapy groups needed three meetings about safety and three meetings about trust. Reaching safety and trust opened the way for participants to start acknowledging each other's grief and caring for each other. The phase of care developed quite naturally from the previous phases. In the care phase visible changes could be observed. Sociotherapy group participants paid more attention to their skin, hair, and clothes. They washed themselves more often. Clothes were ironed and women paid more attention to the combination of colours in their clothing. Usually, starting with the fifth, sixth or seventh sociotherapy group session participants greeted each other and showed more intimacy. Several trainees had also observed that during these same meetings participants no longer talked mainly via the facilitator, but also started to share parts of their stories about the present and the past with each other. In this way social relations began to be built.

In Dekker's analysis, the trainees see the care phase as a phase of recognition. The establishment of safety and trust creates a space that invites participants to recognize each other's distrust, complaints and grief, whether these are expressed openly or remain hidden. At the moment that participants discover that there is a will in the group to recognize the other, the tension caused by continuous fear and frustration may disappear. It is the attention and gestures that people notice among fellow participants and sociotherapists that show them that they are indeed recognized as human beings. This whole process also develops more or less naturally out of people's positive experiences during the previous phases.

Some caution is justified. Not all participants can have the floor in the same meeting to share their stories that have been bothering them for so long. Most participants, however, sense that their turn to also tell their story will come. For some that moment will never come. The active process of recognition going on in the group gives its participants the feeling that the potential is there to give them the specific care that they need from other group members. With that perspective, sociotherapy group participants start feeling a togetherness which they have known in the past and which they trust. However, "one cannot expect each group member to be equally caring for another" (sociotherapist).

A sociotherapy group shares togetherness by sitting together, praying, playing games, joking, singing, dancing, communicating through body language and talking. The renewed feeling of togetherness gives them hope for the immediate future. The sense among group members that they have autonomously developed a kind of horizontal democracy often has an immediate spin-off to new family and community relationships outside the group. Furthermore, the bonding and bridging (between peo-

ple of different ethnicities) that develops within a sociotherapy group generates new energy to make constructive decisions about one's life in connection to that of non-group members. They start greeting people whom they did not greet before, sharing drinks with others, and going to weddings. The achieved intra-group bonding and bridging on a horizontal level is also the stepping stone to linking social capital, for instance in the form of approaching civil authorities for care and support in solving one's own problems, those of others or shared problems.

One of the more experienced sociotherapists adds in a discussion with colleagues a few important elements to what happens in the phase of care. While the phase of care starts to confirm among group participants the feeling of togetherness, they start to feel free and confident to speak to each other. "They are coming out of the hiding place they had fallen into with their problems." In this respect many participants like to quote the proverb *Ujya gukira indwara arayirata* (If you want to heal from a disease you talk about it). They start to give testimonies about what happened to them. "When they take the medicine of sociotherapy well, they can help others when they see that they have problems that are similar to the ones they had before." In the process of 'coming out' during the phases of care and respect one can often observe a change in the language people use. Participants at the start of the program have the tendency of saying 'we' instead of 'I'. "They want to hide behind the group. As is common in Rwanda, they like to talk in general terms about themselves by saying, for example, 'we teachers' or 'we soldiers'. It goes away when they have been talked to or taught in group discussions. That is when you start to hear them saying 'I': 'I was', 'I used to be afraid of talking when I am with people', 'I was afraid of going where others are'. They remove that general coat and instead put on a personal coat" (sociotherapist).

Remaking the moral world

In summary, sociotherapy starts a process of remaking the moral world that was destroyed by war and genocide. A common feature of what people share across categories is the loss of a shared sense of moral orientation and trust, resulting, for instance, in a lack of the traditional and much valued social togetherness, a loss of dignity, and lingering stigmatization. There are many Rwandan proverbs which express the importance of living in harmony with other people and being no one without another. One of them is *Kubaho ni ukubana* (The value of existence is to be with others). The moral system expressed in this proverb fell in disorder in Rwanda and people feel threatened by this disorder.

People use various means in sociotherapy groups – for instance, story telling and role-play – to express what is troubling them. The verbal and non-verbal ways of expression 'do moral work' (cf. Bamberg 2006; see also Walker 2006). They provide a basis for an interactive evaluation of the 'rightness' or 'wrongness' of whatever is being reported. Group members subsequently advice on what they think is morally the best way to behave. This can be to forgive the person, who wronged you, or to not present the case discussed in the group to a court but solve it among the people

who are involved. Many discussions in the sociotherapy groups focus on conflicts. The three types of conflicts mostly addressed in the groups are family conflicts (such as domestic violence), conflicts due to incompatible interests (for instance disputes about the ownership of a piece of land), and conflicts related to ethnic differences. This illustrates that the Hutu/Tutsi dichotomy is far from being the only division in Rwandan society.

Sociotherapy helps people to regain self-respect, rebuild trust, feel safe again, overcome unjustified self-blame, re-establish a moral equilibrium, have hope, live without terror, forgive those who have harmed them, apologize to those whom they have wronged, and regain their rightful place in the community. Walker (2006: 23) defines moral repair as "the task of restoring or stabilizing – and in some cases creating – the basic elements that sustain human beings in a recognizably moral relationship." In this article we approached moral relationships by way of Arendt's concept of *inter-est*; the web of human relations, which in post-genocide Rwanda is in need of moral repair. The repair of the moral values that held the society together in the past which sociotherapy helps to make possible is not done without critical examination of which values should be maintained and which should be discarded. The idea of sociotherapy is to create a community in sociotherapy groups in the 'reverse image' of the society at large – a morally shattered society – in order to be therapeutic for the casualties of that society. The sociotherapy principles and phases are meant to put that reverse image into practice. Sociotherapy introduces, for instance, a form of democracy and equality on the level of families and communities that was non-existent in pre- and post-war Rwandan society. People in Rwanda often express a longing for the societal harmony and family prosperity of the past. However, some of the characteristics of pre-war society and family life were 'mistrust, oppression, and sometimes cruelty' (Newbury 1998).

Being-in-the-world is always being-with, and "being with others in the world necessarily includes caring for and being cared for" (Kleinman & Van der Geest 2009: 160). The breakdown of this being-with (in Arendt's words, the *inter-est*), is according to Zigon (2007) very similar to what Foucault called problematization. Zigon identifies the moment of moral breakdown, or the moment of problematization, as the ethical moment, the moment in which ethics must be performed. In Rwanda, however, what happened in terms of moral breakdown was so frightening, overwhelming, incomprehensible and unreal that a large part of the population felt incapable to 'perform ethics' or could only do so selectively (cf. Fujii 2009).

Zigon makes a distinction between morality as the unreflective mode of being-in-the-world and ethics as a tactic performed in the moment of moral breakdown. "It is in the moment of breakdown, then, that it can be said that people work on themselves, and in so doing, alter their way of being-in-the-world" (Zigon 2007: 138). Because, Zigon writes, people cannot live in a permanent state of moral breakdown, they must respond to the ethical demand and return to the everydayness of unreflective moral dispositions. For many Rwandan people also in the aftermath of the political violence, the moral breakdown of society is so all-encompassing and complete that even in this period they did not find anything to hold on to that could help them to respond to 'the

ethical demand'. As one sociotherapy program staff member said: "They take every straw they can find to pull themselves out of the morass of moral chaos and poverty." Sociotherapy was considered by many of its participants as such a straw. In sociotherapy people find care that enables the majority of them to climb out of the morass and start the process of individual and social recovery. Follow-up research is needed to monitor this process and study its effect in the long term.

Our presentation of the positive impact of sociotherapy in terms of individual and social healing has regularly been received with at least a tint of disbelief. In particular, the cases on reconciliation between people of different ethnicities raise doubt about the authenticity of what we (and implicitly our respondents) report.[5] A common reaction by outsiders to the sociotherapy program is: how can reconciliation be possible after the horrific events that took place in Rwanda? In this article we have tried to find some answers to this question. An additional answer is that precisely because of the extreme horror that people experienced, they are more than ready to move on. Rwanda is a post-conflict society where victims and perpetrators are condemned to share the same social space where death and destruction have taken place. Sociotherapy is capitalizing on that shared social space and uses it to contribute to social reconnection.

Notes

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1 See for a more nuanced summary of the history of the political violence – including the development and propagation of a corporate view of ethnic identity while on the ground ambiguous and fluid ethnic identities kept existing – Fujii 2009, Newbury 1998, Richters 2010.
2 See for a full description of the background and set up of the program: Richters et al. 2008a and b, Richters 2010.
3 The facilitator of Veronique's sociotherapy group later confirmed this weight gain. According to him it was approximately 15 kilo's. In more of our case studies weight gain features prominently.
4 Throughout Rwanda one can see prisoners in pink outfits working group-wise on public service projects by day and returning to prison at night.

5 Antje Krog received similar reactions from white South Africans and foreigners who were uncomfortable about the attitudes of forgiveness of black South Africans in the context of the reconciliation process instigated by the Truth and Reconciliation Commission in South Africa. She analyses these reactions as an ethnocentric response to something remarkable that originated among black South Africans and that may help South Africa to break out of cycles of violence (Krog 2009: 204-206).

References

Arendt, H.
1958 *The human condition*. Chicago: University of Chicago Press.

Almedom, A.M.
2005 Social capital and mental health: An interdisciplinary review of primary evidence. *Social Science & Medicine* 61 (5): 943-64.

Bamberg, M.
2006 Stories: Big or small: Why do we care? *Narrative Inquiry* 16 (1): 139-47.

Coletta, N.J. & M.L. Cullen
2000 *Violent conflict and the transformation of social capital: Lessons from Rwanda, Somalia, Cambodia, and Guatemala*. Washington, D.C.: World Bank.

Field, J.
2003 *Social capital*. London and New York: Routledge.

Fujii, L.A.
2009 *Killing neighbors: Webs of violence in Rwanda*. Ithaca: Cornell University Press.

Herman, J.L.
1992 *Trauma and recovery: The aftermath of violence – From domestic abuse to political terror*. New York: Basic Books.

Jackson, M.
2002 *Politics of story telling: Violence, transgression and intersubjectivity*. Copenhagen: Museum Tusculanum Press.

Kleinman, A. & S. van der Geest
2009 'Care' in health care: Remaking the moral world of medicine. *Medische Antropologie* 21 (1): 159-68.

Krog, A.
2009 *Begging to be black*. Capetown: Random House Struik.

Laub, D.
2002 Testimonies in the treatment of genocidal trauma. *Journal of Applied Psychoanalytic Studies* 4 (1): 63-87.

Newbury, C.
1998 Ethnicity and the politics of history in Rwanda. *Africa Toda*y 45 (1): 1-15.

Poortinga, W.
2006 Social relations or social capital? Individual and community health effects of bonding social capital. *Social Science & Medicine* 63 (2): 255-70.

Richters, A.
2010 Suffering and healing in the aftermath of war and genocide in Rwanda: Mediations through community-based sociotherapy, in L. Kapteijns & A. Richters, eds. *Mediations of violence in Africa: Fashioning new futures from contested pasts*. Leiden: Brill, pp. 173-210.

Richters, A., C. Dekker & W.F. Scholte
2008a Community based sociotherapy in Byumba, Rwanda. *Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict* 6 (2): 110-16.
Richters, A., S. van Brakel & C. Dekker (eds.)
2008b *"Here we are": Community-based sociotherapy in Byumba, Rwanda*. Heemstede: SMART.
Thurman, T.R. et al.
2008 Barriers to the community support of orphans and vulnerable youth in Rwanda. *Social Science & Medicine* 66 (7): 1557-67.
Walker, M.U.
2006 *Moral repair: Reconstructing moral relations after wrongdoing*. Cambridge: Cambridge University Press.
Zigon, J.
2007 Moral breakdown and the ethical demand. *Anthropological Theory* 7 (2): 131-50.