

# Intergenerational Legacies of the Genocide in Rwanda and Community Based Sociotherapy

Identifying and Addressing Pathways of Transmission

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## Executive Summary

This policy paper reports results of research conducted by the Netherlands Institute for the Study of Crime and Law Enforcement (NSCR) and the Community Based Socioterapy Program (CBSP), funded by NWO-WOTRO, Applied Research Fund of the Security and Rule of Law program. The research aimed to: (i) understand *how* legacies of the 1994 genocide against the Tutsi, its aftermath and related experiences are transmitted to the next generation of Rwandans through processes within families; and (ii) identify *whether* and *how* sociotherapy can play a role in addressing such pathways of intergenerational transmission. Previous research has demonstrated long-lasting and intergenerational effects of mass violence on individuals, families and communities. In Rwanda, the 1994 genocide and its aftermath led to large-scale individual traumatization, disruption of family structures, shifts in gender roles, increase in familial violence, and continuing tensions within communities. In the aftermath of the genocide, sociotherapy has been implemented in Rwanda to contribute to improving psychosocial wellbeing of individuals, enabling interpersonal reconciliation and strengthening social cohesion.

Findings showed *direct* and *indirect* pathways by which legacies of the genocide and its aftermath are transmitted to the second generation within families. The direct pathways of intergenerational transmission concern the ways in which the genocide (and other acts of violence), its aftermath (e.g. Gacaca, imprisonment) and related events (e.g. displacement, exile) are reflected upon, reconstructed and explicitly communicated or silenced to children. The indirect pathways of intergenerational transmission are the ways in which the genocide and its aftermath affect the second generation's socio-ecological environment, and through that, the socialization environment of the child. Examples include the effects on (i) family structures (e.g. missing family members due to death or imprisonment); (ii) family functioning and parenting (e.g. suffering of parents makes parents less sensitive to the needs of their children); (iii) family socio-economic situation and status (e.g. poverty); and (iv) community relationships (e.g. processes of stigmatization and shame or feelings of jealousy and inequality or mistrust within communities). The pathways are all interrelated and interact in various ways.

Findings also showed that sociotherapy has the potential to address both direct and indirect pathways of intergenerational transmission through its intervention. We exemplify direct communication as a direct pathway and poverty as an indirect pathway of intergenerational transmission. Firstly, CBSP facilitates direct communication about past or current suffering in the sociotherapy group sessions. Communication seems to serve as a therapeutic tool for sharing among participants, but is not (yet) addressed as a *direct pathway* of intergenerational transmission of legacies of the genocide within families. Secondly, poverty and other indirect pathways of intergenerational transmission of legacies of the genocide may be more explicitly targeted. Through the sociotherapy sessions, CBSP facilitates group-based cooperation. Consequently, a number of its (former) participants have taken the initiative to start collaborative economic activities, to help them in their struggles to improve their living conditions.

In brief, in order to prevent negative consequences of the 1994 genocide on the second generation, it is recommended that CBSP exploits possibilities to address direct and indirect pathways of transmission more purposefully. To further develop practice-oriented strategies, future research

should investigate most effective tools. In addition, the positive and negative effects of direct communication about the genocide or a lack thereof on the second generation requires further investigation.

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## Background

Previous research has demonstrated long-lasting and intergenerational effects of mass violence on individuals, families and communities. In Rwanda, the 1994 genocide against the Tutsi and post 1994 justice related experiences, such as those related to the Gacaca community courts and imprisonment of mainly male genocide suspects or convicts, led to large-scale individual and collective traumatization, disruption of family structures and shifts in gender roles. Furthermore, the aftermath of the genocide has been related to elevated rates of domestic violence (Rieder & Elbert, 2013) and ongoing struggles among survivors, perpetrators and their family members to cohabit in communities (Buckley-Zistel, 2006).

To address some of these challenges, the Community Based Sociotherapy Program (CBSP) has been implemented in Rwanda. CBSP aims to improve psychosocial wellbeing of individuals and strengthen interpersonal reconciliation and social cohesion at the community level. It is designed as an alternative to individually focused (and thus expensive) trauma therapy (Dekker, 2016). It uses the group setting as a therapeutic medium for establishing trust, opening space for discussion and establishing peer-support structures (see below for more information; Richters & Sarabwe, 2014).

This policy paper reports on findings from a research project that aimed to understand, firstly, the intergenerational legacies of the genocide among Rwandan families, and second, the potential effects of sociotherapy implemented in Rwanda by CBSP on the process of intergenerational transmission of the genocidal legacies. The focus was on the pathways through which legacies of traumatic experiences of the 1994 genocide and its aftermath are passed on to the second generation within families in Rwanda. Special attention was given to the relation and interaction between mothers and their children.

The research project was conducted by the Netherlands Institute for the Study of Crime and Law Enforcement (NSCR) and CBSP, and funded by NWO-WOTRO, Applied Research Fund of the Security and Rule of Law program.

## Intergenerational transmission in Rwanda

Previous research offers evidence for the intergenerational transmission of violence, trauma and other mental health problems in post-conflict environments (see for example: Weingarten, 2004; Saile et al., 2014; Betancourt et al., 2015; Roth, Neuner & Elbert, 2014; Betancourt & Williams, 2008). Research also shows that parenting behaviors affect the intergenerational transmission of trauma and violence, either as risk or protective factors (Berckmoes & Reis, 2016; Gewirtz et al., 2008). For instance, due to parents' traumatic experiences, parents may become less sensitive to children's needs or less available to their children, which can subsequently affect developmental outcomes, such as children's well-being, educational achievements and social behavior (Berckmoes & Reis, 2016; Gewirtz et al., 2008; Roth, Neuner, & Elbert, 2014). In addition, besides parental traumatic experiences, there are indications that multiple other ecological factors at family and societal levels shape developmental outcomes of children growing up in post-conflict settings, including changes in family structure, such as loss of caregivers, poverty and other daily life struggles (Betancourt et al., 2015).

In Rwanda, after recurrent outbreaks of mass violence since 1959, the 1994 genocide and its aftermath led to drastic changes in family and societal structures. Of a total population of over 7 million, it is estimated that over 1 million people were killed (Rwanda, Ministry of Local Government, 2002). Roughly, 56 percent of them were men (Ibid). Many women survived as captives, often subjected to extreme violence, and consequently, continue to struggle with their physical, mental and social wellbeing (e.g. Neugebauer et al., 2009). Tens of thousands of individuals fled to neighboring countries and/or were (often upon their return from exile) detained, tried and imprisoned on genocide related charges by normal criminal and Gacaca community courts (Clark & Kaufman, 2008). As such, the sex ratio and traditional gender roles in Rwandan society have been significantly modified (Rutayisire & Richters, 2014). Women had to step into the void left by men and attend to roles traditionally occupied by men (Schindler, 2010). Also, many women had to provide for their husbands who were and sometimes still are detained, often in poor conditions (Tertsakian, 2004). Furthermore, evidence seems to suggest that increased marital conflict and intimate partner violence can partly be attributed to genocide- and Gacaca-related factors (Rutayisire & Richters, 2014; Umubyeyi et al., 2014; Sarabwe, Richters, & Vysma, 2017).

In this context, a deep concern exists over the potential intergenerational transmission of the legacies of the/ negative consequences of the 1994 genocide and its aftermath - from those who have experienced the genocide directly to those who have not directly experienced it (i.e. the children that were not born yet in 1994). However, there is limited understanding of the mechanisms underlying intergenerational transmission of experiences of mass violence and responses to it and how to best address this phenomenon through policy and practice. In this research project we use qualitative research to explore intergenerational legacies of mass violence in Rwanda, specifically the 1994 genocide and related events. We investigate *how* legacies of the genocide are being transferred from one generation to the next within families, *what role* CBSP plays in addressing the intergenerational transmission, and we identify possible avenues for improvement.

## Community Based Sociotherapy Program in Rwanda

Community based sociotherapy was initiated in Rwanda in 2005. To serve the massive psychosocial needs among the Rwanda population in the aftermath of the war and genocide in the best possible way, the clinic-based sociotherapy approach, as applied in psychiatric clinics in support of the treatment of traumatized refugees in the Netherlands, was adapted to the Rwandan post-genocide context and transformed in a community-based approach. Its objectives were to foster feelings of dignity, safety and trust among the Rwandan population, reduce mental and social distress and reduce disturbed and delayed development. Due to the positive effects of the approach within the communities targeted by the intervention, in 2014 a three-year nation-wide sociotherapy program was implemented to address in particular effects of the Gacaca (community justice) process that ran from 2002-2012. The program in these three years was named Community Based Sociotherapy Program in post-Gacaca Rwanda (CBSP). In these years CBSP further developed into a trauma informed psychosocial peacebuilding program.

Sociotherapy in Rwanda is practiced in sociotherapy groups (socio-groups) of an average of ten to fifteen people. The groups meet for approximately three hours a week, for a period of fifteen weeks.

The meetings are held in a place which is located in the direct living environment of group participants which they consider as safe. Two trained sociotherapists methodologically guide the groups through the sociotherapy phases of safety, trust, care, respect, new life orientations and memories. Throughout the journey the following seven principles are applied: interest, equality, democracy, participation, responsibility, here-and-now and learning-by-doing. The sociotherapy phases and principles guide the group through a process of healing and social reconnection. The group members are facilitated to share ideas, adapt one's behavior, take care of each other. In consultation with each other, they try to address their present problems and to support each other in processing painful memories. It provides the participants with a new understanding of the issues affecting their feelings, thoughts and behaviors, and enables them to think about the future again in constructive ways (see for more information: [www.sociotherapy.org](http://www.sociotherapy.org)).

## Methodological approach

To understand how children are affected by mass violence experienced by their parents and its aftermath, we departed from Bronfenbrenner's ecological model on child development (1977). Our focus was on processes of intergenerational transmission in the primary environment in which children grow up, namely the household or the family. We were particularly interested in the relationship and interactions between the mother and (one of) her child(ren), as representing respectively the first and second generation. We approached the family environment as embedded within the community environment, and influenced by the more distal, wider society. The sociotherapy program was approached as part of the community environment, similar to mother's participation in other potential sources of institutional support such as church groups, community solidarity groups and relations with neighbors.

The research included 41 households. As many households are female headed, as a result of male imprisonment or death, we focused on mothers who experienced the genocide and their adolescent children who had not consciously experienced any of the 1994 events. The participants in the study were sampled through the sociotherapy program. We included a group of mothers who were going through (or had already gone through) the program ( $N=22$ ), and a group of mothers who had not (yet) gone through it ( $N=19$ ). Of the latter group, most women were on the program's waiting list at the time of the research. In both groups, mothers with different social and economic backgrounds were included. To account for differences in socio-economic conditions and regional variation in genocidal violence, post-genocide justice, and consequently variation in potential legacies of the genocide, the research sites were geographically spread across Rwanda. We included seven districts in four Rwandan provinces: North, South, East and West. We used qualitative research methods.

A team of five trained Rwandan researchers with relevant educational backgrounds (e.g. psychology, sociology, social work) conducted in-depth, semi-structured interviews with mothers who had lived through the genocide and with their adolescent children, who were born in or recently after 1994. Mothers were interviewed twice. The first interview focused on the household circumstances and negative and positive events experienced over the life course, including the genocide. The second interview explored family relations, particularly with the child identified to be interviewed, and the way the mother experienced and dealt with negative events, including the genocide. The interview with the child explored how they experienced their household, the relationship with their mother, and the influence of sociotherapy or other sources of support on their family life (cf. Berckmoes & Reis,

2016). All interviews were recorded, verbally transcribed and translated by a qualified Kinyarwanda-English translator. The interviews were thematically analyzed by the first and second author, using Atlas.ti to develop a coherent coding scheme. The coding scheme encompassed both the themes that, based on the literature, had been identified in the research design phase and new themes that were identified inductively.

## Ethics

Permission for this research project was granted by the Rwandan Ministry of Health and ethical approval was obtained through the Rwanda National Ethics Committee (No.552/RNEC/2016).

Before the start of each interview, participants were informed about the research objectives and process as well as their rights to participate both verbally and through an 'informed consent' form. Furthermore, informants were explained that they could refrain from answering specific questions or withdraw at any moment. Informed consent was obtained from both mothers and children. The respondents were explained that the information obtained would be used for research purposes only and that reporting would not contain information that could be traced back to individuals. We also notified participants that we would transcribe, anonymize and securely save the interviews and audio files, in line with data management guidelines of the NSCR.

Respondents were selected through CBSP and were either former participants or on the waiting list for enrolment. This ensured that respondents had access to trained community sociotherapists, if necessary. To enable research uptake for improving interventions for the intergenerational impact of the genocide and related events, findings have been shared with stakeholders in the Netherlands and with CBSP staff and its implementing partners in Rwanda. Preparations are made for further dissemination of results in Rwanda.

## Findings

Our first aim was to understand *how* legacies of the 1994 genocide, its aftermath and related experiences may affect the next generation of Rwandans through family dynamics. Based on an analysis of all interviews with mothers and children, we identified several pathways of intergenerational transmission of legacies of the genocide within families, which can be categorized as either direct or as indirect (see Figure 1).

The direct pathways of intergenerational transmission concern the ways in which the genocide (i.e. acts of violence) and its aftermath are reflected upon, reconstructed and explicitly communicated, or not, to the second generation. Thus, how mothers talk about or silence past events in interactions with their children are examples of pathways of direct intergenerational transmission.

The indirect pathways of intergenerational transmission are the ways in which the genocide (i.e. violent acts), its aftermath and related events, affect the second generation's socio-ecological environment, and through that, the child. Examples include the effects on (i) family structures (e.g. missing family members due to death or imprisonment); (ii) family functioning and parenting (e.g. suffering of parents makes them less sensitive to the needs of their children); (iii) family socio-economic situation and status (e.g. poverty, for example as a result of looted property or of paying reparations); or (iv)

community relationships (e.g. processes of stigmatization and shame or feelings of jealousy and inequality or mistrust within communities).

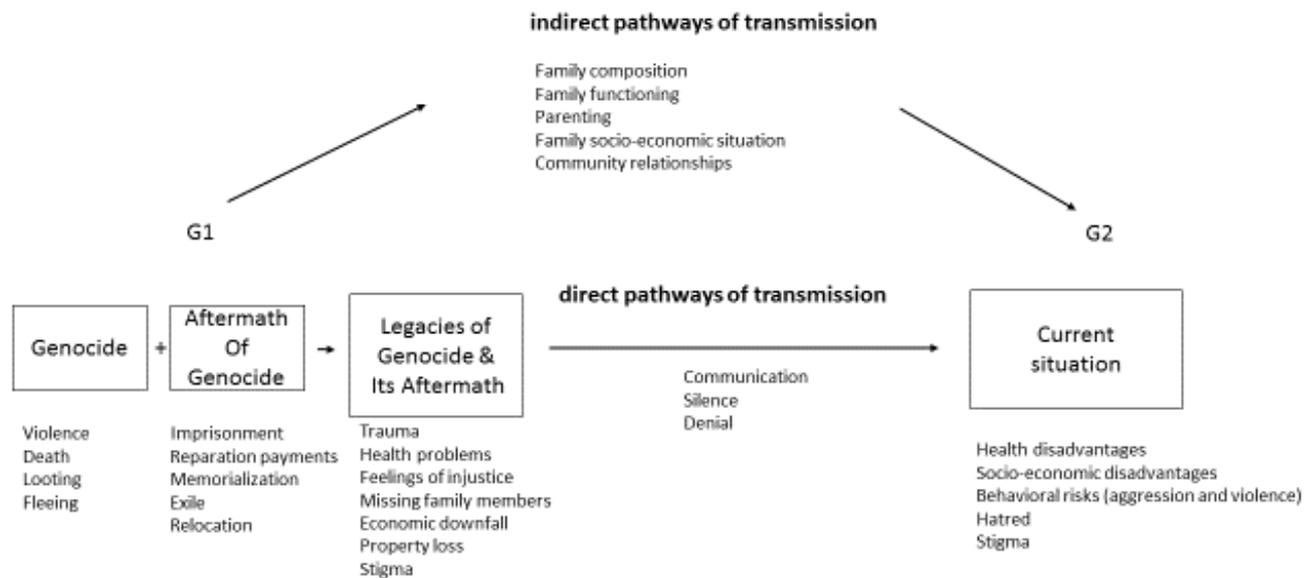


Figure 1. Pathways of transmission

## Direct pathways of intergenerational transmission

We identified a large variety of ways in which mothers communicate with their children about the genocide, in terms of how and what is being communicated. The patterns of communication consisted of either explicit, verbal communication or a lack of communication between parents and their children, in the literature often referred to as 'silence/ing' (see for example Weingarten, 2004). An example of explicit, verbal communication is shown in the narrative of a young man (aged 18) who describes what his mother shared about her experiences during the genocide:

*It means that during that period [...] we used to sit down, and she would tell us stories [about the past]; in fact, when you often talk to your parents, they tell you a lot of things. So she would tell us those who killed her parents; she would tell us their living conditions before, in those hard moments.*

**Household #19, son, aged 18, mother is genocide survivor and ex-participant CBS**

Motivations for verbalizing or silencing the experiences of the past varied. Most commonly, mothers expressed hesitance to share the stories about the genocide and related events with their children. They appeared concerned about the effects these stories may have in keeping the past alive, wanted to reassure their children by not showing their struggles, or felt that it served no purpose to recount these past stories. Their narratives included remarks such as 'letting go of the past', 'bygone is bygone', 'it is history' or 'I have transcended it'. Some mothers felt that children would not understand and the need to move on, albeit out of necessity:

*I can't see any major effects because what some people don't understand, during the genocide for instance, they were not there. I mean these young ones. But they have reconciled themselves to their father's death, we all live with it. We share the responsibilities that he should be fulfilling and no one gets overtired. Besides, there are things against which you cannot do anything. That's the reason why we have to accept it.*

**Household #13, mother, aged 59, genocide survivor, widow, ex-participant CBS**

Other mothers worried that their children, should they hear the stories, would come to hate others or seek revenge.

*Interviewer: [..], do you think that current or past conflicts are likely to affect future generations from the families that experienced them?*

*Respondent: This must happen; for example, when a child asks you: what happened to your family? Who killed them? Right? In the future, they will say: it is these ones who killed our grandfathers, our aunts, our cousins. They will say: long ago Hutus killed Tutsis, they were in power of such and such ...; let us also kill them. Our grandfathers also were in power of such and such... On one side, there will be children who will not know the families of their parents. You see, some children's fathers are in prison, right? They also say: I wish someone could show me who had my parents jailed. Right? They would say: we would also kill them.*

**Household #10, mother, aged 40, genocide survivor, mixed marriage, ex-participant CBS**

The annual commemoration period and the presence of 'genocide memorials' in all parts of the country (NIOD; Links, 2014 "Preserving History in Rwanda") show that remembering the genocide is engrained in everyday life in Rwandan society. For mothers and children, issues regarding communication or silence about the genocide appeared to become most explicit during the genocide commemoration period, which takes place each year in the month of April. This national mourning period concerns 100 days of official commemoration and is traditionally launched every year in a ceremony initiated by Rwanda's current president. In this period, otherwise largely private suffering becomes part of the public domain. Still, not all suffering emanating from the genocide, its aftermath and related events are communicated openly. For instance, our interviews show that feelings like mistrust or hatred against people who killed or who are responsible for imprisonment of others are not often shared or discussed publicly because they may be considered part of 'genocide ideology' or 'divisionism', which is forbidden and criminalized by Rwandan law (Genocide Ideology and Divisionism Laws; Human Rights Watch).

### **Indirect pathways of intergenerational transmission**

In Rwanda one cannot go past the fact that in many families, children grow up in single-parent households, face difficult economic circumstances and have limited access to institutional support, education and (mental) health care (see also: Rieder & Elbert, 2013). These circumstances may be related to the genocide and related events, meaning that transmitted legacies of the genocide and its aftermath may manifest themselves through the adverse conditions in which the child grows up. We identified a number of such indirect pathways of intergenerational transmission, including poverty; disturbed family structures such as missing or unavailable family members; and compromised family functioning, which sometimes became manifest in marital conflict or violence, or inadequate

caregiving. Of course, each of these pathways are likely to be interrelated: due to the absence or unavailability of family members, specific family tasks are no longer fulfilled, or parents may have limited possibilities to provide basic needs to their children, which subsequently means that they are less available because they are occupied with procuring a livelihood. Moreover, many parents suffer from physical or mental illness. In this section, we describe poverty as one of these indirect pathways of transmission. Throughout our interviews with mothers and children, in all provinces, poverty was mentioned as a strong concern and at least partly related to the genocide and related events.

In most interviewed families, both mothers and adolescent children expressed fears about economic 'falling' and the wish to 'improve conditions'. Many families had experienced economic downfall after the genocide. Some families had lost land and cattle through looting during the genocide, some mentioned conflicts over land ownership as people returned to Rwanda after years of exile, and others were confronted with post-genocide transitional justice mechanisms such as (substantial) payments of reparations, which – as they are a family responsibility – drained family economic resources, and could lead to feeling doubly victimized:

*I was harmed by the death of relatives and I was harmed by the effect of paying damages to the survivors who accused my husband to take materials during genocide (gusahura) during Gacaca period.*

**Household #27, mother, aged 47, widow, paid reparations, ex-participant CBS**

More indirectly, families had lost family members – often men and other male relatives – who could have participated in the economy of the household. In these households, mothers had become primarily responsible for the household economy, often with little resource for help in the extended family. As such, being a mother was by many experienced as a heavy burden. Mothers also expressed worries about not being able to help their children prepare for independent house holding. Some mothers expressed feelings of frustration, anger and injustice for the events that had caused the poor living conditions and limited opportunities to improve their household conditions:

*The events I experienced resulted in my being overwhelmed by too much work in the household due to poverty following the genocide. Facing problems means not to be idle or not to be discouraged and stop working. I work although there are failures; I'm not discouraged by the failures. I work hard in the field although the moles eat the crops, but I don't give up. I keep facing the problems so that I can lift myself out of poverty. I cannot stop breeding animals fearing that they may be stolen. I try to lift myself out of poverty.*

**Household #41, mother, aged 52, genocide survivor, widow**

For children, the consequences of the economic hardship and downfall manifested themselves in the first place in the lack of fulfillment of basic needs. For instance, several children were prevented from going to school as mothers could not pay for uniforms or other school material:

*It's true, compensation took place, of course I paid with difficult[y], but it is painful to me because I paid compensation for things that I never saw and which I don't know what they look like; I feel that this is also a burden to me, but because there was no option, I accepted it. I tell myself: that is what has happened and I feel that I'm not the only one who experienced this;*

*but each person knows his [own] case. But I say: the money I paid could have enabled a child to go to school, but it happened like that. I accept it because there is no option. Yes.*

**Household #12, mother, aged 40, prisoner's wife, paid reparations, non-participant CBS**

Yet, we saw with many children that they felt deeply responsible for the household conditions and tried to step in where caregivers were failing. Although it is quite common in many African societies for children to participate in the running of the household (e.g. Levine et al., 1994; 2008), among the sampled households, burdens on the young ones appeared heavy. Children did not always know about the cause of the economic difficulties in their families, or had not (completely) understood:

*Child: Because they [i.e. parents] had cut trees, and were requested to refund them. That is all I know about the case [i.e. obligation to pay reparations].*

*Interviewer: Was your mother the only one to suffer from that problem?*

*Child: Yeah, she was the most to suffer because she did not cut the trees herself.*

*Interviewer: Yes! Oh... Does it have consequences on the relationship with her?*

*Child: Of course, because she has paid money, the whole household has suffered.*

**Household #6, daughter, aged 20, mother is genocide survivor and ex-participant CBS**

## Pathways of intergenerational transmission and CBSP

After identifying how legacies of the genocide are transmitted across the generations, the second aim of the research project was to identify whether and how CBSP can play a role in addressing these pathways of intergenerational transmission.

With regards to **direct pathways of intergenerational transmission**, some respondents mentioned that the CBSP has stimulated them to share personal stories about their own experiences during the genocide, also with their children. For instance, this respondent describes how – after joining a sociotherapy group – she finally dared to take her children to a memorial site, which stimulated open discussion with her children about past experiences of violence:

*But now, I feel such behavior [referring to her emotional absence and feelings of anger and frustration during the commemoration period especially] is weakening away, because of the community sociotherapy program I have joined. This year particularly, I dared taking my children to the memorial site. When I uttered my testimony on the dark moments with genocide, the children have come to realize that my behavior is seriously hindered by the genocide and they encourage me. At the moment, such an event no longer threatens me to the extent of disturbing my children.*

**Household #23, mother, aged 47, genocide survivor, mixed-marriage, ex-participant CBS**

With regards to **indirect pathways of intergenerational transmission**, CBSP addresses issues related to (mental) health of caregivers, family functioning in terms of marital relationships or relationships with children and issues related to stigma in the community, albeit not explicitly as a pathway of intergenerational transmission. Mothers we spoke to mentioned their sociotherapy group's focus on 'healing', its group-based promotion of forgiveness and the importance of 'moving on'. They noted that the intervention had helped them living with the suffering they had experienced and feeling

human again. Some felt that they could 'relativize' and in a way 'normalize' their suffering because they noticed that other people may be worse off than they themselves are. Other mothers reported that sociotherapy helped them stop avoiding places or people that remind them of events that happened during the genocide, or to help coming out of isolation from the community.

*They said: "We can now start talking about this issue, then after fifteen days, we shall start some healing program with you." From the discussion we had that day, I felt satisfied. I was taught to visit the persons we were having problems with: "Please, feel free with them. You should no longer be on bad terms each other, greet them as you pass. Talk to them." That day we had a good discussion.*

**Household #28, mother, aged 45, widow, ex-participant CBS**

Sociotherapy appears, however, not to be directed at indirect pathways of intergenerational transmission such as poverty and compromised family structures due to the loss of family members. At the same time, we came across various examples in the interviews and our observations in the field that suggest that sociotherapy may bring benefits in this respect. By bringing people together and having them share their past and present experiences, this (indirectly) stimulates group-based socio-economic initiatives. In terms of indirect pathways of intergenerational transmission, this can be said to – to some extent – address the loss of members in the family structure, but especially address poverty, the fear for economic downfall and the need or wish to improve family and individual living conditions. The woman whom we quoted above, indeed, continues her story as follows:

*After the discussion, we were told: 'We are going to start collecting some contribution. After one year, we shall break the box and see the amount of money inside, and each of us will be able to buy something from the contributions. So, you can give your ideas, on the contribution.' I said: 'My idea is that I don't have enough means to pay for my children's school fees; one is going to the secondary school; another has just completed senior three.' Then he [the sociotherapist] told us, because we were trained by [sociotherapists]: 'Our contribution for you will be to collect some money in a box, and at the end of the year, you will have some money to buy pens for your children. That will also be the same for the rest of the group.' [...] To me, that is the importance of the sociotherapy program up to now.*

**Household #28, mother, aged 45, widow, ex-participant CBS**

Similarly, sociotherapy, due to its community based character, enabled socioeconomic initiatives directed at the neighborhood:

*As I told you, my husband is a member of the community based sociotherapy group and that his fellow members lend us a hand during the farming season, which we appreciate a lot. For this reason, this support can't [negatively] affect our relationship with others in this neighborhood. Instead, it is a good opportunity for us to discuss about how we can develop our neighborhood. The most important support is to get constructive ideas which lead to the development of the neighborhood.*

**Household #7, mother, aged 51, genocide survivor, husband is ex-participant CBS**

## Concluding Remarks

In Rwanda, the genocide and its legacies are still omnipresent. The tragic past very much shapes the present and via next generations, may also affect the future.

In this research we took a qualitative approach to explore the intergenerational legacies of the 1994 genocide in Rwanda. Our first aim was to investigate *how* the genocide, its aftermath and related events are transmitted within families to future generations. We focused specifically on relationships and interactions between mothers and their children. Our second aim was to explore how sociotherapy, as introduced in the Rwandan society by CBSP, may intervene in processes of intergenerational transmission in Rwanda. We interviewed mothers who completed sociotherapy sessions, and mothers who were still on the waiting list to participate. This enabled us to say something about the potential effects of participation in a sociotherapy group on intergenerational pathways of transmission.

Our findings revealed that legacies of the 1994 genocide, its aftermath and related events are transmitted to the second generation within families through direct and indirect pathways, which are interrelated and interact in multiple ways. The direct pathways of intergenerational transmission concern the ways in which the genocide and related events are reflected upon, reconstructed and explicitly communicated, or not, to the second generation. The indirect pathways of intergenerational transmission are the ways in which the genocide affects the second generation's socio-ecological environment, and through that, the child. In this policy paper, we specifically focused on communication (or a lack thereof) as the direct pathway of intergenerational transmission, and poverty as an example of the indirect pathway.

*Direct* pathways involve the communication with or towards children about negative events of the past. A lack of communication with children or the 'silencing' of past events (Weingarten, 2014) was also observed. Silencing may be a deliberately chosen strategy, for example for mothers not to show their struggle. Silence as a way to 'let go of the past' was also described as a way to be able to live peacefully together and to focus on the future. CBSP facilitates direct, verbal communication about difficulties with regard to daily life struggles, which may be related to the genocide (e.g. living together with perpetrators). Some of our interviewees noted that directly confronting the past and sharing their traumatic experiences enabled them to 'relativize', or normalize, their suffering. They saw that other people also suffer and may even be worse off. With regards to the intergenerational family bonds and relationships, open communication about the genocide and its legacies can lead to children's increased understanding of their present struggles. At the same time, we know from the literature that it can also generate frustration, open old wounds or lead to traumatization. Our data is inconclusive with regards to the effects of sociotherapy on both whether and how the past is communicated towards the children and on what the effects are of the direct open communication, or silence, for the second generation.

With regards to the *indirect* pathways of intergenerational transmission, in this policy paper we focused on poverty as the most salient example of an indirect intergenerational pathway. Economic downfall as an (in)direct result of the genocide, its aftermath and related events was frequently referred to by both mothers and children as hampering them in their daily lives and obstructing

opportunities for the future. For children, the consequences of the economic hardship and downfall manifested themselves in the first place in the lack of fulfillment of basic needs, their inability to attend school and therewith secure their future. They reported feeling obliged to alleviate family poverty by contributing to household activities and generating sources of income. Sociotherapy appears not to be directed at indirect pathways of intergenerational transmission such as poverty. It seems, however, that by bringing people together, enabling them to share their experiences and opening up to each other, sociotherapy (secondarily) stimulates group-based cooperation and socio-economic initiatives among its participants. This in turn enables people to potentially improve their economic conditions and eventually alleviate poverty and economic hardships.

## Policy recommendations

Our research shows that legacies of the genocide are transmitted to the second generation in complex ways. Negative consequences often manifest themselves in the socio-ecological environment of the child. To intervene in the intergenerational transmission processes, therefore, CBSP may – in their further implementation of sociotherapy in Rwanda – want to find ways to address some of these pathways in the socio-ecological environment more explicitly. The community and group based format may be especially useful. Indeed, albeit not in a direct or targeted way, CBSP already does touch upon several pathways of transmission.

Sociotherapy, as introduced in Rwanda by CBSP, is designed to improve the well-being and functioning of, in this research, the first generation or parents, as well as stimulate interpersonal reconciliation and social cohesion. In this way, CBSP may (inadvertently) influence indirect pathways of intergenerational transmission, namely *communication*, by ultimately affecting the stories parents will tell their children about the past, and (*mental*) *health* of parents, which may affect the parenting and other aspects that influence the child's socio-ecological environment. To target intergenerational legacies of the genocide, its aftermath and related events more directly, in their further implementation of sociotherapy, CBSP might want to consider focusing explicitly on these and other pathways of intergenerational transmission, by:

- Encouraging the group to address parenting, family relations and family interactions explicitly, in order to help each other to secure a safe environment for their children to grow up in;
- Stimulating and supporting the group to develop economic cooperation among its participants and within the community in order to reduce poverty, and facilitate potential collaboration with partners (see below);
- Encouraging the group to fulfill the roles of absent family members by taking care of each other, or each other's children, thereby fulfilling roles generally ascribed to family members – and thus extending their relevance to the children – this may aid specifically in order to prevent negative consequences for next generations.

To complement their own work and help further exploit beneficial 'side-effects' – such as the effects on poverty and on supporting the formation of broader social networks for parents – CBSP may want also to explore partnerships with other organizations who can aid in specializing in these other aspects.

Challenges encountered by the second generation in Rwanda, may also potentially affect subsequent generations. We therefore think that CBSP's recent growing attention for intergenerational processes

(for example by forming sociotherapy groups with second generation children) is extremely important and well chosen.

To conclude, by purposefully addressing *intergenerational transmission* within their existing program and its community based structure, CBSP may be even better equipped to improve conditions for future generations of Rwandans.

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