Genocide and mass sexual violence: Psychological support for women survivors in Rwanda

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This article highlights how sexual violence is used against women and girls during war and genocide. It outlines the longer term impacts of such violence and presents a framework for psychological intervention in Rwanda, in the aftermath of mass rape.

MASS RAPE and forced pregnancy are recognised as a weapon of war (Milillo, 2006) and have been documented in wars and genocides throughout history, such as Soviet occupied Germany (1945–1949), Bangladesh (1971) and Bosnia-Herzegovina (1992–1995). Wartime rape was finally recognised as a crime against humanity in international law following the genocide in former Yugoslavia (Buss, 2002). Genocide involves the destruction of a nation or ethnic group, perpetrated through mass killing, but also through the disintegration of culture, language, personal liberty, dignity, health and security (Lemkin, 1944). The use of sadistic practices, such as rape in war, are designed to erase the identity of the victim and cause maximum psychological damage to the community under attack. Whilst there is a human rights and legal literature around gender-based violence and rape in war, there is less about the psychological impacts upon women who suffer this crime. Zraly and Nyirazinyoye (2010) review literature indicating that rape survivors may be faced with unwanted pregnancy, gynaecological injuries, sexually transmitted infections, post-traumatic stress disorder and other psychological problems, including suicidality. Whilst women are often the target, sexual violence against men has also been documented to be widespread in war affected countries and can bring with it a myriad of physical and psychological consequences for individuals and communities (Storr, 2011).

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Understanding context:
The Rwandan experience

The 1994 genocide against the Tutsi in Rwanda occurred against a context of previous ethnic conflict and mass killings. The complex origins of the genocide have been linked to the impact of colonialism, and the resulting heightened ethnic divisions between the Tutsi, Hutu and Twa peoples. In the 1994 genocide, the Tutsi population was attacked. Moderate Hutus were also killed. The genocide was planned and predicted but, despite warnings, there was an inadequate international response. It is estimated that between 800,000 and 1,000,000 people died in 100 days. The genocide was widespread, and the violence was often perpetrated by people who attacked and killed or raped their Tutsi neighbours.

Rape was used as an instrument of war, and men infected with HIV were trained to rape and deliberately infect women. It is estimated that 250,000 to 500,000 women were raped (Foundation Rwanda, 2008). Twenty-two years on from the Rwandan genocide against the Tutsi, many are still impacted by those traumatic events. There are women survivors of the trauma who have felt silenced and shamed by

what happened to them: rape was used to systematically humiliate and damage women, and to inflict long lasting effects upon the Tutsi community. Many women became infected with HIV and/or became pregnant as a result.

For women who suffer rape, Van Ee and Kleber (2013) comment that: 'Even after many years, the trauma of rape continues to have a major impact on women's lives.' Pregnancy as the result of rape can serve as a 'living reminder' of trauma. There is growing evidence that maternal trauma can be transmitted to children via biological as well as psychological mechanisms (Yehuda et al., 2005). Attachment between the child and mother can also be severely disrupted (Van Ee et al., 2012; Van Ee & Kleber, 2013). However, there is also evidence that some women are able to construct a positive meaning around their pregnancy despite their traumatic experiences (Van Ee & Kleber, 2013). The psychological responses that women experience, both in the short and long term, need further research. Hogwood et al. (2014) highlight that the impact of rape is multiplied if the woman becomes pregnant. They also comment that the '…destruction of the social fabric deprived these women of the social connections necessary to rebuild their lives and deal with the trauma', as many people lost relatives, friends and other sources of support (p.393).

Gender-based violence in Rwanda

It is estimated that thousands of children were born due to rape after the the 1994 genocide against the Tutsi in Rwanda (Torgovnik, 2009). Wax (2004) reports that survivor groups believe the number of children could be between 10,000 and 25,000. It is hard to establish exact figures due to underreporting. Few studies have explored the effect on the mother–child relationship, though there is evidence that impacts can be severe. In the aftermath, some women died by suicide, some had terminations, some carried the babies to term but gave them away and some decided to keep the children (Human Rights Watch, 1996). Women who kept their babies may have lost many or all of their relatives. Others have struggled to maintain positive relationships with their families because of deciding to keep the child. There can be complex family conflict, and there are instances of women being disowned by family because they chose to keep 'a child of the killers'. Many women have had to continue living in communities alongside the men who raped them, and have had to raise their child in the community where they suffered victimisation. The longer-term impacts for those mothers and young people are unknown; neither is it known how many children suffer transgenerational trauma, or develop their own resilience.

Zraly and Nyirazinyoye's (2010) ethnographic study of women who survived genocide-rape comment that '…the process of resilience appeared to be patterned by the culturally specific concepts…' and that resilience was connected to '…an intrapsychic creative process of drawing strength from within the self in order to withstand suffering' (p.1662).

Working with genocide survivors

Survivors Fund (SURF; www.survivors-fund.org.uk) was established in 1997 and has a range of projects to support survivors of the genocide against the Tutsi in Rwanda. The specific project for supporting women with children conceived through rape is part of a larger range of survivor support. Initially, the women requested practical help – needing financial assistance for their children to attend school. This gave women hope that their child would be able to find work and care for themselves and their mothers into old age. However, the needs of women changed over time and many started asking for help with what to tell their children about their origins. Mothers had often fabricated stories to protect their child from the truth and because it was still too painful to talk about traumatic events. Adolescence is a crucial time in identity formation and mothers faced more questions from their sons and daughters about their fathers.

SURF identified that many of the mothers had never disclosed their experiences of rape to anyone, even during previous counselling. Focus groups were conducted to explore how to best support the women. Following this, a decision was made to use a community group

Table 1: A flexible guide to session by session topics

Session	Topic
1	Introductions and creating a therapeutic contract
2	Active listening skills and supporting each other
3	Understanding trauma symptoms and triggers
4	Sharing life stories before and after genocide
5	Understanding how trauma can affect children
6	Understanding adolescence (from a child development perspective)
7	The rights of the child and responsibilities of parenting
8	Family conflict and ways to resolve it
9	Sexual health and sexual relationships
10	Considering disclosure: the advantages and disadvantages
11	Improving communication and practising disclosure conversations
12	Saying goodbye and endings

counselling approach (Hogwood et al., 2014) – a flexible, culturally adapted programme within a clear framework of session by session topics. With such complex trauma, clinicians are often working at the margins of the evidence base – an issue common to many therapists working with trauma, particularly that which has involved interpersonal violence.

Survivors' struggles are often accompanied by severe poverty, hunger and housing issues. The women's basic needs are often not met and it can be hard to engage in therapy effectively for this reason. Group topics can often be diverted to the current and immediate needs that women are facing. This means that the topic of disclosure has to be delayed due to more pressing issues. It is also important to understand trauma within a cultural and gendered context. For example, marriage and having children have particular significance in terms of rites of passage in Rwandan society; a girl transitions into womanhood once she has become sexually active and had children. Some of the women had been married at the time of the attacks. Some were young girls when they were raped, and were left confused about their cultural identity and the meaning of what was inflicted upon them (Mukamana & Brysiewicz, 2008).

A framework for psychological intervention

The programme is designed to run fortnightly for six months, for a total of 12 sessions. A maximum of 10 women are accepted per group, all living in a similar geographical area, with the group being closed and run by two trained counsellors. The overall aim of the group is to provide a safe and supportive space to share stories, meet others with similar experiences and increase social support networks.

The women meet in their communities, which increases the likelihood of sustainable impacts, as they can continue meeting once formal counselling has finished. One group member explained the importance of the group process:

> *'I always thought that I was the only one suffering from having a child that was born out of rape, but after our group discussion I got to know that it is no longer my concern as an individual, but our concern as a group. Sharing our experiences gave me more hope and strength.'*

The programme only partially focuses on disclosure work, and disclosure issues are discussed near the end of the programme, after careful scaffolding around a range of earlier topics which lay the foundations for discussions about more difficult material (see Table 1). The programme includes psycho-education about trauma and understanding triggers to trauma memories. Many women experience triggers to highly disturbing memories and flashbacks, and struggle to make sense of these experiences. Explaining symptoms and triggers aids understanding and a sense of control over memories.

The programme also includes psycho education around the responsibilities of being a parent and the rights of children. The UN Convention on the Rights of the Child is taught in schools, and provides a platform for this work. Adolescence is an emerging concept within Rwandan society, so child development concepts are introduced and discussed. These sessions also explore family conflict. One frequent theme is helping mothers learn to distinguish between the perpetrator and their growing sons, who may have physical similarities to the man who harmed them. Topics also cover learning to distinguish between adolescent mood changes and the violence perpetrated by the child's father. Moth-

Table 2: Selected evaluation data from 200 group members

Measure	Session 1	Session 6	Session 12	Six month follow-up
Life satisfaction (Average rating from 0-10)*	2.6	5.2	7.0	6.8
Hope for the future (Average rating from 0-10)	4.0	5.9	7.6	7.4
Feeling a part of the community (Average rating from 0-10)	3.4	-	7.2	7.1
Relationship with child (Average rating from 0-10)	6.6	-	8.8	8.6
Experiencing difficult thoughts 'all of the time'	38.5%	-	5.3%	3.9%
Have 'no-one' to talk to about my problems	46.6%	-	6%	2.8%

* Where 0 is the worst score and 10 is the best.
Note: These are culturally adapted measures, specifically designed for the Rwandan context and developed using an ethnographic approach.

ers often misattribute adolescent behaviour as a catastrophic sign of the child being 'no good' rather than framing it as normal adolescent behaviour. One group member commented:

> *'The groups helped take the shame away from the fact I gave birth to a child from rape and helped me accept my child.'*

An estimated 60 per cent of women who suffered rape were infected with HIV. Many women showing signs of sickness attributed this to their own 'badness', not realising that they were physically unwell. Sessions cover heath issues: a recent development is psycho-education around menopause, as many women were unaware of the signs, symptoms and related biological changes, and were often misattributing it to traumatic experiences. This led to more intimate discussions around sexual relationships.

Only once these earlier topics had been covered in the programme, could women begin to talk about their fears of disclosing their past to their children. Earlier topics provided solid grounding to progress towards disclosure. It was extremely difficult for the mothers to explain to their child what happened, when they had never had the opportunity to talk or think about their own trauma. The other topics helped the women take steps towards thinking why disclosure might be important or necessary. Throughout the programme, it is made clear that it is the mother's choice whether to disclose to their child, but the counsellors help to explore the advantages and disadvantages of speaking out. It appears that the majority of the mothers think that it is important for their child to know the truth, but often don't know how to begin that conversation or what to say, and worry about the child's reaction.

The programme has already reached 420 women, but many more would benefit from participation. Culturally adapted ways to evaluate the efficacy of the work are being developed, looking at life satisfaction, hope, relationship with children, social connectedness, and whether the mother is still experiencing distressing symptoms which are hard to manage (see Table 2). Discussions with group members to understand the impact of the counselling groups also reveal the personal experiences and benefits:

> *'I always felt that no one was as miserable as me and that everybody hated me. When I joined the group, I met others like me and they became my friends, and they have helped me. Three months after the closing of the group, I approached my child during the school holidays. I knelt down and asked her for forgiveness because I have always treated her badly and left her alone. I told her why, and that it was not my fault, but it was due to problems I could not bear. Then I was able to tell her about her background because she was always asking me about her father. Before, my reaction to her questions was nothing other than beating her. Now I am alright and I live well with my child. If I had not had the chance to participate in the group, I would have committed suicide, leaving my child as an orphan, but now I try to enjoy life.'*

Summary and conclusion

Mass sexual violence has often been used as a weapon of war and genocide, and is often underreported. There are approximately 59 million forcibly displaced people globally, around a quarter of whom are refugees (UNHCR, 2016). In the current global context of forced migration, it is important for psychologists to develop skills in working with survivors of mass violence.

We call for further resources to be allocated to the prevention of mass sexual violence and further genocide. There is also now enough data on genocide to identify warning signs for mass killing and mass rape. This can allow planned prevention and intervention responses (Jones, 2011). Responses where there is meaningful prevention work offer promising results for improved gender equality, and also seek to work with men and boys in reducing violence (Ellsberg et al., 2015).

Post-genocide work is crucial to help vulnerable populations, both in the immediate aftermath and in the longer term; people may suffer ongoing mental health problems and

transgenerational trauma, which could render wider society vulnerable to further conflict. Such work requires a multisectoral response, and psychological support is an important component of supporting victims and aiding community recovery (WHO, 2000).

The example of work with survivors of the genocide against the Tutsi in Rwanda provides a framework for working with women who have suffered long-term effects from rape. Clinical psychology has much to offer, in partnership with survivors; we must pay attention to, and better understand the needs of, women who have suffered wartime rape, and their children, in order to build resilience and ensure that they are healthy, supported and integrated within their communities.

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