HHS Public Access

Author manuscript

SSM Ment Health. Author manuscript; available in PMC 2024 December 16.

Published in final edited form as:

SSM Ment Health. 2024 December ; 6: . doi:10.1016/j.ssmmh.2024.100328.

Genocide as communitarian breakdown: Interventions for relational healing and individual wellbeing in Rwanda and Cambodia

Elena Lesley[a,*], **Jessica Laure Bonumwezi**[b], **Sopheap Taing**[c], **Christina Marea**[d], **Su Balasubramanian**[e], **Giorgi Minasovi**[f]

[a]University of South Florida, 4202 E Fowler Ave., Tampa, FL, 33620, USA

[b]Loyola University Maryland, 4501 N. Charles St., Baltimore, MD, 21210, USA

[c]TPO-Cambodia, Oknha Vaing Road (St 1952), Sangkat Phnom Penh Thmey, Khan Sen Sok, PO Box 1124, Phnom Penh, Cambodia

[d]Georgetown University, School of Nursing, 3700 Reservoir Rd, NW, Washington, DC, 20057, USA

[e]Columbia University, School of Social Work, 1255 Amsterdam Ave., New York, NY, 10027, USA

[f]Georgetown University, Graduate School of Arts and Sciences, 3520 Prospect St., NW, Washington, DC, 20057, USA

1. Introduction

According to the United Nations, nearly 2 billion people globally are living in an area affected by violent conflict – roughly one quarter of humanity. UNHCR estimates that at the end of 2021 there were 89.3 million people who were forcibly displaced by conflict, violence, human rights violations, or events disturbing public order – the vast majority of whom are hosted in low- and middle-income countries and nearly half of whom are children (UNHCR, 2021). UNICEF estimates that over 400 million children under 18 years of age are growing up in countries affected by war or violent conflict. Exposure to violent conflict and/or forced displacement can have a profound impact on mental health, with ripple effects for family, community, and social cohesion. Globally, mental health challenges are estimated to affect more than 1 billion people (Rehm and Shield, 2019). Violent conflict may exacerbate existing psychological vulnerabilities, and cause the development of

*Corresponding author. eslesley@usf.edu (E. Lesley).

CRediT authorship contribution statement

Elena Lesley: Writing – review & editing, Writing – original draft, Supervision, Methodology, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Jessica Laure Bonumwezi:** Writing – review & editing, Writing – original draft, Formal analysis, Data curation, Conceptualization. **Sopheap Taing:** Writing – original draft, Data curation, Conceptualization. **Christina Marea:** Writing – original draft, Conceptualization. **Su Balasubramanian:** Writing – original draft, Conceptualization. **Giorgi Minasovi:** Writing – original draft, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

additional forms of distress related to the exposure to violence, destabilization of family and community life, and worsening of chronic life stressors (Miller and Rasmussen, 2017; Garry and Checchi, 2020).

In the case of genocidal violence, damage within families, communities and nations can be especially acute. The concept of genocide emerged out of the drive to respond to sub-national violence against civilians that, until World War II, had been a "crime without a name," as described by Winston Churchill. Raphael Lemkin, himself a Polish Jew, had already been developing the concept of genocide even before the events of World War II after having learned of Ottoman massacres of Armenians during World War I. The term itself was formed from combining the ancient Greek word *genos* (race, tribe) with the Latin *cide* (killing). A desire to respond to the Nazi Holocaust after World War II infused new energy into his earlier campaign, and the UN Convention on the Prevention and Punishment of the Crime of Genocide was adopted by the UN General Assembly in 1948, defining genocide as a number of specified acts "committed with intent to destroy, in whole or in part, a national, ethnic, racial or religious group." A number of scholarly circles have expanded this definition, allowing for the possibilities of collectivities such as political or social groups as potential targets of genocidal crimes (Lesley, 2014). For example, Sociologist Helen Fein described genocide as "sustained purposeful action by a perpetrator to physically destroy a collectivity directly or indirectly, through interdiction of the biological and social reproduction of group members, sustained regardless of the surrender or lack of threat offered by the victim" (Fein, 1993).

Different studies demonstrate the high prevalence and long-term consequences of mental health challenges caused by mass organized violence in post-genocidal contexts (Der Sarkissian and Sharkey, 2021; Rieder and Elbert, 2013). Experiences during genocidal violence such as witnessing the deaths of loved ones, witnessing massacres, sexual abuse, kidnapping, and seeing dead and mutilated bodies can all leave lasting psychological imprints. Studies of mental health conditions in the Rwandan post-genocidal context highlight significant changes in both mental and physical health; some of the most prevalent mental health challenges found by researchers have been PTSD, anxiety, depression, suicidal tendencies, and substance use disorders (Rieder and Elbert, 2013). Having been targeted specifically for one's group identity can also have lasting mental health effects. For example, in her long-term fieldwork among Khmer Rouge survivors in Cambodia, Lesley (2022) has found increased responses of trauma-related distress related to revealing one's identity and details about one's personal life among former "New People," those who were more likely to have been targeted by the regime for their membership in particular social groups, such as educated elites (Lesley, 2022).

Yet because genocide is a form of violence that targets collectivities, it is critical to look beyond individual psychological effects, and to consider relational wounds. The presence or absence of social cohesion has been implicated in recovery from both physical and psychological illness (Bruhn, 2009). But genocidal violence often tears communities apart, rupturing relationships and making it difficult for members of collectivities to trust one another. For example, studies of aging Holocaust survivors have shown that many were plagued by feelings of mistrust strong enough to be considered paranoia, and they reported

intense experiences of loneliness and isolation (Adams et al., 1994; Nadler and Sokal, 2001). Scholars have also found that levels of depression and demoralization were related to the levels of social support survivors experienced after the war (Fenig and Levav, 1991). A study of perceived mental health effects resulting from the genocide against the Tutsi[1] in Rwanda identified the concepts of *guhahamuka* ("mental trauma") and *agahinda* ("grief') as being related to the violence that took place in the country. Both of these have a number of relational components such as "isolation" and "difficulty interacting with others" in the case of *guhahamuka* and "feeling disconnected from others," "fleeing from people and hiding," and "lack of trust" in the case of *agahinda* (Bolton, 2001).

In this piece, we expand on anthropological works that convey trauma in terms of social connection, arguing that processes of psychological recovery always have a critical relational component, and this is especially true in post-genocidal contexts. Lester has written that,

> "A traumatic event is traumatic precisely because it sheers us off from our expected connections with others, from our perceived social supports … If we think of'trauma' as a relational injury rather than a purely intrapsychic or structural one, we can see even more clearly that, however it is locally defined, it is hardly over once the immediate danger has passed—it simply enters a new phase" (Lester, 2013: 754)

In cases of violence where collectivities have been targeted, the relational rupture is especially pronounced. Thus, when considering approaches to healing, we must truly envision the individual as an actor enmeshed in networks of relationships, and these relationships are critical targets of intervention. In trying to rebuild wellbeing in post-genocidal societies, people must begin to re-suture to those around them through a number of different mechanisms. For example, Campbell and Burgess describe how communities can advance Global Mental Health efforts, which have often been framed in more biomedical and individualistic terms (Campbell and Burgess, 2012). They argue for the creation of "community mental health competence" through the sharing of mental health-related knowledge, the creation of "safe spaces" in which people can cultivate a "critical consciousness" of structural factors undergirding distress, and partnerships between local communities and other stakeholders that can contribute to the improvement of mental health (Mahr and Campbell, 2016). In addition, interventions that create opportunities for dialogue and interaction between historically divided groups can also contribute to relational healing (Fonesca and Jovchelovitch, 2023).

This paper emerged from a two-day workshop held at Georgetown University in Spring 2023 that brought together scholars and practitioners from around the world to consider major challenges to, and innovations in, the field of Global Mental Health. One area of critical concern identified by participants was the relationship between mass atrocity and

[1]It is important to note that the categories of Tutsi and Hutu and their origins remain somewhat contested and fraught. The "Hutu Power" movement within the country that led to the genocide resuscitated racialized colonial tropes of the Tutsi as an alien race (Mamdani, 2001). Since the victory of the Rwanda Patriotic Front, the state has favored a narrative stressing that Tutsi, Hutu, and Twa lived peacefully together before colonial intervention and that the designations were social categories based on class and wealth in the form of cows.

mental health, and the authors worked together to identify two in-depth case studies of locally-shaped interventions in post-genocidal contexts that have critical implications for mental health and collective wellbeing.

The first is the "Victim-Perpetrator Dialogue" project in Cambodia, an initiative created by Cambodia's leading mental health NGO to improve mental health among survivors of the Khmer Rouge regime by restoring relationships between victims and their direct perpetrators. Although focused on the victim-perpetrator relational dyads, the project also involved a number of family members in the therapeutic process and was meant to serve as a model for both family networks and larger communities. The second intervention is the *Sugira Muryango* ("strengthen the family") initiative in Rwanda, which is a 12-module, play-based parent coaching intervention funded by various NGOs and foundations and delivered by a government-based volunteer child protection workforce (Betancourt et al., 2020). Although *Sugira Muryango* was created to improve responsive parenting and family functioning, and not envisioned with the goal of addressing the mental health legacy of the genocide, as the intervention was rolled out, it became clear practitioners needed to engage with ongoing psychological distress and social ruptures.

In both Rwanda and Cambodia, violence was "highly local" (Lordos et al., 2021: 106). Violations were often perpetrated by those one knew-family, friends, and fellow community members – as opposed to anonymous strangers, and people have continued to live in these often-strained communities. This means that efforts to retether individuals to those around them have had to proceed with great care. Although *Sugira Muryango* and the Victim-Perpetrator Dialogue Project had somewhat different initial targets and foci – child development outcomes, responsive parenting, and family systems, versus survivor mental health and relations between direct victims and perpetrators – each ultimately had to grapple with the inextricable linkage of individual mental health to relational healing. A close examination of both cases suggests both the necessity of considering relationships themselves as targets of intervention in post-genocide contexts, but also indicates that initiatives focused on present-day behaviors and interactions (such as *Sugira Muryango*) may prove more feasible in low-resource settings than those that aim to restore problematic past relationships (as with the case with the Victim-Perpetrator Dialogue).

2. Methods

The first case study, on the Victim-Perpetrator Dialogue Project, was compiled by the study's first author, who has worked in Cambodia over the course of the past 20 years. Much of her research has focused on survivors of the Khmer Rouge period and outreach efforts created to address this population in conjunction with the country's UN-backed tribunal. From 2017 to 2019, the first author spent 16 months working alongside staff at the Transcultural Psychosocial Organization (TPO), Cambodia's leading mental health NGO, as they implemented a number of different mental health programs. This research consisted of extensive participant observation and interviews both with staff at TPO and with those engaged in their programs. The information for this particular study of the Victim-Perpetrator Dialogue project came from interviews with staff at the NGO and therapy participants, as well as two videos that were recorded by the organization about the

initiative. The research received ethical permission from the Emory University Institutional Review Board and interviewees were provided with a script about the research and their participation in the Khmer language before giving oral consent.

The case study on *Sugira Muryango* was compiled by this study's second author. As a Rwandan researcher, born and raised in the country, she has had a long-lasting interest in intergenerational trauma. Additionally, her research over the past three years has focused on Rwandan families, investigating psychosocial mechanisms involved in the intergenerational transmission of trauma in children of survivors of the 1994 genocide against the Tutsi. Through this work, she conducted extensive interviews with leaders of genocide survivor organizations and mental health professionals, which is how she came across the *Sugira Muryango* intervention. Most of the information included in this case study came from an in-depth review of published papers and policy briefs on the *Sugira Muryango* intervention as well as publicly available information on various webpages related to the project. The author also interviewed two Rwanda-based program managers and one US-based research scientist from the *Sugira Muryango* study team, all of whom have worked on the study for several years. During the interview with the program managers, they shared an unpublished success story booklet, which is where the participant examples used in this case study were drawn from. The participants gave their consent for their stories to be used in the booklet and their names have been changed to protect their privacy. The study was approved by the Yale University Institutional Review Board and the required ethics review boards in Rwanda. Interviewees provided oral consent.

3. Victim-perpetrator dialogue case study

The violence and disruption of the Khmer Rouge (KR) period shredded much of the community fabric and bonds of trust in Cambodian society. The communist Khmer Rouge regime aimed to completely transform the country's social structure in the quest to build an agrarian utopia in which individuals were loyal to the Khmer Rouge organization, or *Angkar*, above all else. The traditional Cambodian family structure was a target of this campaign, as were village and community bonds. Society was divided into two classes of people, based on their previous socioeconomic and political affiliations. "New people" were those from more privileged backgrounds who were more likely to have had exposure to foreign influences and affiliations with the previous regime that had fought the Khmer Rouge. "Base people," or "old people" were from poorer peasant backgrounds and more likely to have demonstrated loyalty to the Khmer Rouge earlier in the movement's existence. Though base people were generally treated more favorably by the Khmer Rouge state (Democratic Kampuchea, DK), which controlled the country from 1975 to 1979, they were also often targeted for persecution and internal purges. Both base and new people experienced a number of forms of trauma, including starvation, forced movement, forced labor, separation from family, forced marriage, arrest, and physical torture. During the state of Democratic Kampuchea period, roughly 2 million Cambodians lost their lives.

Although the DK period ended with the Vietnamese-backed invasion of the country in 1979, fighting continued in the country up until the late 1990s, when the last remaining KR defected to the current government. In order to try to stabilize the country and achieve peace,

the current government policy has been to accept the majority of former KR into society and to encourage people to bury the past in order to move forward together. One of the dominant narratives circulating in contemporary Cambodia, endorsed by the current Prime Minister, who defected from the Khmer Rouge himself, is that all Cambodians "are victims of the Khmer Rouge" (Path, 2015).

This attitude is reflected in the country's approach to transitional justice, which has focused on legal prosecution of only a handful of top leaders, and widespread amnesty for former Khmer Rouge. Nonetheless, in addition to legal prosecutions, the UN-backed Khmer Rouge tribunal has opened up space and resources for a number of reparation projects that aim to foster reconciliation and strengthen community cohesion.

Yet, in order to work toward these outcomes, many actors associated with reparations projects believed the mental health wounds of the period needed to be addressed. For example, a 2014 study done comparing similar age groups of ethnically Khmer respondents in Siem Reap, Cambodia (a major center of Khmer Rouge violence) and Surin, Thailand (which was not subject to the Khmer Rouge influence at all) found that roughly 50% of Siem Reap residents who had survived the Khmer Rouge period met the clinical threshold for depression, and around 20% met the criteria for PTSD. Percentages among non-Khmer Rouge affected Khmers in Surin were 20% and 2%, respectively (Mollica et al., 2014). Emerging studies have also suggested potential intergenerational impacts from the Khmer Rouge period; a 2013 study by Field et al. found that mothers' PTSD symptoms were predictive of daughters' anxiety levels, and that these relationships were also often characterized by role-reversal parenting (Field et al., 2013).

TPO took the lead in designing and implementing mental health reparations projects associated with transitional justice efforts. TPO champions a culturally-responsive, community-based approach to mental health, and projects are often community-, as opposed to individually-oriented. Because of the blurred lines between victim and perpetrator in much of the Khmer Rouge context, and also in keeping with the government's broad approach to amnesty, many of TPO's projects have focused on community strengthening and testimonial acknowledgement, without much discussion of actions taken by individual perpetrators (Lesley, 2021). One exception to this approach was a Victim-Perpetrator Dialogue pilot project that was funded by USAID and implemented from 2016 to 2019. Many victims of the Khmer Rouge continue to live near those who *directly perpetrated* crimes against them or their family members, and this creates ongoing states of anger, resentment and fear that pollute community relations and strain mental wellbeing. As one victim of the Khmer Rouge said before undergoing therapy, everyday life felt like "pus that was trapped inside an abscess" and he became physically ill around four days out of every week due to his psychological pain and anxiety.

It was because of this ongoing anger and tension between victims and *direct* perpetrators living in close proximity that TPO decided to pilot a victim-perpetrator dialogue project. They built off of a project that had been implemented in 2011 with the collaboration of the Boston-based International Center for Conciliation (ICfC). Although TPO staff had initially proposed that they would reconcile six pairs of victims and direct perpetrators through the

pilot initiative, working intensively over the course of three years, they were only able to facilitate reconciliation between two pairs of victims and perpetrators. While counselors reported that the strength of the intervention lay in the deep and meaningful reconciliation achieved between individuals, families and communities, the organization ultimately was forced to discontinue the program due to associated costs and the intensive staffing that was necessary.

The intervention consisted of four phases: Assessment, video-based dialogues, face-to-face dialogues and a community-based religious ceremony. During the assessment phase, counselors used questionnaires to gauge both victims' and perpetrators' needs and expectations, and also offered an introduction to mental health concepts and to the video equipment they would be using. They then recorded video messages to exchange in order to ease into the idea of meeting face-to-face. In the messages, the parties discussed their views of events from the past and also how they affected their emotional states in the present day. The reactions of each party would also be filmed while watching the recorded messages in order to later exchange. Finally, after exchanging a number of recorded messages, the victims and perpetrators agreed to meet face-to-face in a neutral location to create a shared understanding of the past and to discuss how they could rebuild their relationship. Finally, once the face-to-face meeting had concluded, along with declarations of apology and forgiveness, TPO held a religiously-influenced community-based reconciliation ceremony.

3.1. The case of Uncle Koeurn and Uncle Tha

One of the two pairs that successfully completed the intervention were Uncle Koeurn and Uncle Tha, who both lived in Kampong Chhnang province. In 2014, TPO had organized a film screening and awareness raising event in Uncle Koeurn's village in order to find people to participate in the project. Counselors noticed Koeurn in the crowd because he appeared very downcast, and they asked him to share his story of what had happened during the Khmer Rouge. He explained that during the regime, his mother, brother and nephew were all arrested and taken away to be killed. He added that he remained "full of anger" until this day and he believed that Uncle Tha, who had been a friend of the family before the Khmer Rouge period, oversaw the village during that time and had some responsibility for his relatives' deaths. Today, Tha lives near Koeurn's sister. Koeurn instructed TPO staff to verify Tha's location through his sister, immediately involving other family members in the intervention.

After TPO staff had located Tha, they began the process of learning more about each party's personal situation and recording video messages to exchange. Each participant often appeared with their spouse, who had also been greatly affected by the legacy of the period. For example, Koeurn's wife, Auntie Khon, explained, "I have so much pain in my heart. I can barely speak about their deaths." She added that even though she had the desire to take revenge, she did not do so because Tha lived so close and that his family might retaliate against hers. Koeurn then explained that they did not know if Tha had carried out the killings – they did not have proof he had done so – but that since he had a leadership position in the village at that time, they wanted him to tell them what had happened to their relatives.

In his initial interview, Tha said that he supported the reconciliation process because he believed it would help Koeurn and Khon let go of some of their anger. However, he claimed that even though his father had been a high-ranking official during the Khmer Rouge period, that he himself did not know the fates of Koeurn and Khon's relatives and that he had left to join a mobile unit before they were killed.

The process of exchanging video-based dialogues was difficult and took a good deal of time because Tha at first did not trust TPO staff, and he also continued to deny any responsibility for what had happened. However, over time, Tha began to feel more sympathy for Koeurn and Khon and agreed to meet them in person to discuss what had happened. At the same time, some of the victims' anger lessened as they learned via video messages about Tha's position and the fact that even former Khmers Rouge were afraid to defy orders.

When the face-to-face meeting finally occurred, Tha said he apologized on behalf of his deceased father, if he had done anything to harm Koeurn's relatives. Tha explained that, "during that time, we didn't understand each other, and we didn't know the situation had evolved like that." Koeurn and Khon accepted the apology and said they believed Tha was being honest. Tha said he would like to rebuild his relationship with Koeurn, as well as a relationship between the two families.

The final step in the intervention was the public reconciliation ceremony, which incorporated both Buddhist and Christian elements in keeping with the participants' belief systems. After the ceremony, members of both families planted a "friendship tree" together. When TPO staff have checked back over time, they found that the families have continued to heal their broken relationship and also to water and care for the friendship tree.

Khon, reflecting on the process, commented, "we no longer hold onto our grudges. Our resentments steadily decreased. Before, we did not know the reasons and did not talk, so I was angry. But after talking with him I could think more deeply. Holding onto that anger would be pointless."

3.2. Case of Uncle Lung and Uncle Dung

The second successful victim-perpetrator dialogue also took place between two men who had been "like family" before the Khmer Rouge, but who hadn't talked in many years. Uncle Lung believed Uncle Dung and his wife had taken his father away to be killed. During the period of exchanging the video messages, Dung not only said this accusation was false, but accused Lung of stabbing him with a knife in an act of revenge once the Khmer Rouge were ousted from power. Despite these different perspectives of the past, the parties eventually agreed to meet face-to-face.

Although the face-to-face meeting started out with some tension, both sides eventually softened, and expressed regret for what had transpired between them. They agreed to stop seeking revenge and to meet again for another face-to-face session. After that session, they agreed to hold the reconciliation ceremony, which was based on the Buddhist *Bangsokol* ritual, in which merit is transferred to the spirits of the dead via offerings made to monks. After the ceremony, Lung commented that he felt they had become "like relatives, just like

before." Meanwhile, the son-in-law of Dung said that if the reconciliation did not happen, "this hostility may have spilled over to children and future generations."

A video created by TPO about the case of Mr. Lung and Mr. Dung ends with an illustrative quote from Preah Maha Ghosananda, a leading figure in Cambodian Buddhism during the post-communist period: "A peaceful heart makes a peaceful person. A peaceful person makes a peaceful family. A peaceful family makes a peaceful community. A peaceful community makes a peaceful nation. A peaceful nation makes a peaceful world."

3.3. Strengths and challenges

Although very limited in scope, the Victim-Perpetrator Dialogue project had a number of strengths. Innovative use of technology to mediate initial dialogues between victims and perpetrators proved an effective means of avoiding unnecessary, premature conflict, and of preserving "face" on both sides of the encounter – an important cultural value (Hinton, 1998). Although envisioned as a form of relational healing between two individuals – a victim and direct perpetrator – in keeping with the more collectivist orientation of Cambodian society, counselors accommodated the participation of other family members in the intervention. Spouses, siblings and others often participated in sessions, offering their thoughts and expressing their feelings as well. The repeated exposure to the perspectives of others over time also created opportunities for self-reflection, cultivation of empathy and the transformation of identities. Participants could see similarities between themselves and those they had considered to be enemies, which also created possibilities for reappraisal and reflexivity when thinking about the past. This resembles the findings of researchers in Colombia, who reported that repeated interaction and dialogue between university students and former guerilla fighters enabled a renewal of identities and increased possibilities for mutual tolerance (Fonesca and Jovchelovitch, 2023).

Once the parties in Cambodia had finally agreed to reconcile, a religious-informed ceremony held in their local communities helped involve a broader range of stakeholders, thus serving as a positive model for others and drawing on support of social networks to bolster the staying power of the intervention. As TPO staff checked back over time, they found that multiple members of both victim and perpetrator family networks had continued to work toward relational healing, piece by piece. Both victims and perpetrators also reported feeling more relaxed and experiencing less anxiety, stress and paranoia than before the intervention.

At the same time, the challenges facing this kind of intervention cannot be underestimated. Although TPO had initially planned to reconcile six pairs, they were only able to carry the intervention to its completion with two because in many cases the parties were simply unable to find common ground. In addition, it was very cost and labor intensive, involving more trips than anticipated by therapists to participants' home villages as they slowly built rapport and gained trust on both sides. The Victim-Perpetrator Dialogue project was thus very resource intensive, although it did result in deep and meaningful reconciliation among victims and perpetrators and their family networks, which could serve as a model for their communities at large. As one counselor mentioned, "the deep roots will affect the future generations." Yet TPO was ultimately forced to discontinue the program due to resource constraints, calling into question how feasible such interventions might be in low-resource

settings. In contrast, *Sugira Muryango* is an example of an intervention that appears to offer more possibilities for sustainability and "scale-up" in post-genocidal contexts, both due to the less contentious nature of the relationships involved and the clear relevance to current behavior and everyday life. At the same time, *Sugira Muryango* may have been more appealing to a broad range of donors given the prioritization of mothers and children in Global Health efforts (Pillay et al., 2022).

4. Sugira muryango case study

As was the case in Cambodia, the genocide against the Tutsi in Rwanda resulted in a massive loss of life and family ties. From April to July of 1994, an estimated 1,000,000 people were killed (Dyregrov et al., 2000; République du Rwanda, 2004) and a significant number of survivors, especially those from areas of the country that were hit particularly hard by the genocide, were the sole survivors in their families (Richters et al., 2010). Among survivors, 21% were orphans and 10.3% were widows due to the genocide (National Institute of Statistics of Rwanda, 2008). It is estimated that over 70% of survivors experienced the death of a close family member (Dyregrov et al., 2000; Pham et al., 2004) and those survivors lost an average of seven immediate family members during the genocide (Gishoma et al., 2014).

There were also several changes to family structure in survivor families. First, many households in post-genocide Rwanda were headed by women, as the victims of the genocide were overwhelmingly male (République du Rwanda, 2004). Furthermore, the genocide resulted in thousands of children being orphaned or separated from their families. Therefore, an estimated 37% of households were headed by children (Ng et al., 2015) and thousands of children lived in these child-headed households (Schaal and Elbert, 2006). Following the genocide, there were also 77 residential care facilities or orphanages caring for around 12,700 children, which represented more than a two-fold increase from an estimated 4800 children placed in residential care before 1994 (United Nations Children's Fund Rwanda, 2021).

Additionally, it is noteworthy that most people killed during the genocide were killed by friends, neighbors, and even family members (Dyregrov et al., 2000; Fujii, 2011). Various examples of intra-family violence have been documented. For instance, Ingabire et al. (2022) described the case of "Alex" a Rwandan young man with a survivor mother and paternal uncles who betrayed his mother and assaulted her with machetes. Another, more famous case is the case of Albert Nsengimana, writer of the book "*Ma mére m'a tué*" ["my mother killed me"]. Albert was seven years old during the genocide and was one of nine brothers, children of a Tutsi father and a Hutu mother. Based on the Rwandan system of ethnic inheritance, they were considered Tutsi. During the genocide, Albert's mother arranged the killing of her husband and eight of her sons. Albert, the sole survivor, miraculously escaped with his life.

Because of the extreme violence that characterized the 1994 genocide against the Tutsi, it had a considerable impact on the mental health of survivors, which in turn significantly affected their parenting and family life. A nationwide epidemiological study recently found

a depression prevalence of 35.0%, a PTSD prevalence of 27.9%, and a panic disorder prevalence of 26.8% among genocide survivors (Kayiteshonga et al., 2022). For comparison, in the general Rwandan population, this same study found a depression prevalence of 12.0%, a PTSD prevalence of 3.6%, and a panic disorder prevalence of 8.1%. Moreover, 48.8% of male genocide survivors and 53.3% of female genocide survivors were reported to have some kind of mental distress. For orphans living in child-headed households or in orphanages, these numbers were even higher with 44% of them having probable PTSD (Schaal and Elbert, 2006). As for children who were the heads of households, 82% had probable PTSD (Ng et al., 2015).

These changes to family structure and parents' mental health challenges resulted in significant changes to childrearing practices in Rwanda. Like other genocide survivor parents (including in Cambodia), survivors in Rwanda have been reported to often display maladaptive parenting styles including overprotective parenting and rejecting parenting as well as impaired family communication styles (Berckmoes et al., 2017; Bonumwezi, 2022; Field et al., 2013; Giladi and Bell, 2012; Ingabire et al., 2022; Jensen et al., 2021; Kahn and Denov, 2022; Rowland-Klein and Dunlop, 1998). Furthermore, many of the survivor children who were orphaned by the genocide grew up without role models for healthy parenting, later leading to difficulties in parenting their own children.

These challenges in post-genocide family life have been shown to lead to the transmission of trauma from survivor parents to their children. Several studies have documented the intergenerational transmission of trauma in genocide survivor families in Rwanda, with an estimated 42% of children of survivors having probable secondary PTSD and 37.8% having clinically significant symptoms of depression or anxiety (Bonumwezi, 2022). One subgroup of children of survivors experienced even more severe mental health concerns than most (Uwizeye et al., 2021). This subgroup is the estimated 2000 to 10,000 children who were born as a result of genocidal rapes in Rwanda (Bijleveld et al., 2009). These children experience significant social challenges related to identity and belonging, often face stigma, marginalization, and abandonment in their families, and typically experience strained relationships with their survivor mothers (Denov, 2015; Kahn and Denov, 2019). Our findings and those of others have documented that children of parents with PTSD are more severely affected by intergenerational trauma (Bonumwezi, 2022; Shrira et al., 2019) and that parenting styles and family communication mediate this transmission (Bonumwezi, 2022; Kahn and Denov, 2022). Furthermore, research suggests that the specific ways in which survivor parents talk to their children about their genocide trauma – often characterized by silence and a lack of disclosure – play an important role in this transmission (Bonumwezi, 2022; Berckmoes et al., 2017; Williamson Sinalo et al., 2020). However, it is notable that the main reason cited by Rwandan parents for silencing their genocide-related trauma is to maintain peace in the community and avoid future violence such as through revenge-seeking (Ingabire et al., 2022).

5. Rwanda's approach to healing and the *Sugira Muryango* program

Mental health recovery in Rwanda has tended to fall on two ends of a spectrum – from nationalized to individualized approaches. Countrywide village-level hearings (the *Gacaca*

trials) and an annual national period of genocide commemoration have been proposed as measures that help facilitate psychological healing through testimonial catharsis. Yet, these initiatives can also prove emotionally overwhelming and retraumatizing for some participants (Brounéus, 2008). At the same time, the country's public mental health agenda emphasizes individual psychological and psychiatric care. Still, efforts to address mental health using community-based approaches and relational repair have had promising results. Psychosocial support groups have been shown to enhance perceived physical and mental health among HIV patients (Thomson et al., 2014), a participatory socio-therapy program showed improved mental health and social cohesion (Scholte and Alastair, 2014), and "Life Wounds Heal" workshops created by a Rwandan psychologist have led to increased community mental health competence through creating safe spaces for dialogue and building bonds between different groups (Mahr and Campbell, 2016).

Although *Sugira Muryango* was not initially conceptualized as a mental health intervention, it nonetheless targeted relations that had broader implications for psychological healing. The project emerged from the government's national childcare reform in 2012 which established the "*Tumurere Mu Muryango*" [Let's raise children in families] program. In addition to closing residential care facilities for children, the initiative strengthened government agencies and structures charged with child protection (United Nations Children's Fund Rwanda, 2018). The *Sugira Muryango* project was launched as a collaboration between the Research Program on Children and Adversity at Boston College School of Social Work, the University of Rwanda, and FXB-Rwanda (a local NGO). It is a 12-module home-visiting, play-based, parent coaching intervention delivered by volunteer lay workers in Rwanda that aims to improve responsive parenting, family functioning, and child nutrition, with the goal of promoting early childhood development (Betancourt et al., 2020). Over time, the intervention team was forced to grapple with the impact of the intergenerational transmission of trauma as a parenting intervention located in a post-genocide context, and has shown promising findings related to improvements in parenting skills, family functioning, and child outcomes.

The intervention specifically targets rural families with children under the age of three who are designated by the Rwandan government's *Ubudehe* wealth ranking system as belonging to the lowest socioeconomic category. The families in *Ubudehe* 1 category are typically families that struggle to independently meet their basic needs, do not own their home or cannot afford to rent adequate housing, and do not hold consistent employment or do not have income-generating activities that offer them a consistent livelihood (Rutikanga, 2019). The intervention has been linked to the Rwandan social protection program and is delivered by *inshuti z'umuryango*, a volunteer child protection workforce that was established by the Rwandan government in 2016. By improving parents' caregiving and problem-solving skills and increasing parents' understanding of early childhood development (ECD), *Sugira Muryango* is intended to help parents create a more safe, engaging, and nurturing environment for young children to support their development and wellbeing. The intervention also incorporates connecting caregivers to community resources (e.g., center-based ECD programs, social support), training parents in emotion regulation and coping skills, teaching parents conflict resolution strategies, and the development of a "family narrative" to counter violence risk and foster resilience to challenges.

The project is currently in its expansion phase and was set to impact around 10,000 vulnerable rural households in Rwanda by the end of 2023 (Betancourt, 2022). A multi-actor collaborative partnership is currently working on the adaptation, quality improvement, and scale up of *Sugira Muryango* to ensure long-term expansion, sustainability, and integration into government-delivered services. Follow-up studies are also assessing the cost-effectiveness of the intervention, its long-term impact on outcomes such as school readiness, and its spillover effects on siblings of children who participated in the original *Sugira Muryango* large CRT study (Betancourt et al., 2022).

6. Participant testimonies

6.1. Communication and conflict resolution

Testimonies from *Sugira Muryango* participants that have been compiled into a success story booklet attest to substantial positive changes in family life as a result of the intervention. The most consistently reported improvements were around marital harmony, sharing of family responsibilities, and joint decision making, especially regarding finances. Families also testified to significant improvements in communication and conflict resolution skills. An example of this is the family of Innocent and Chantal who reported that Innocent's problematic substance use was leading to conflict, poverty, and intimate partner violence. Thanks to *Sugira Muryango*, they started communicating more effectively and making family decisions together. Innocent also started treating Chantal better and their relationship improved. At the end of the intervention, Chantal shared "I will always be grateful for the profound impacts the program has had on my husband and the changes it has made in his behaviors. The start of the program in June 2021 was the start of a new relationship with my husband. This has been a year of much happiness."

Dramatic changes in child development outcomes were also reported by participants. That was the case for Josée and Faustin, whose 30-month-old daughter, Alice, was suffering from mobility and speech difficulties that had been unable to be treated at various hospitals. By the end of the intervention, the child was able to express herself using gestures and had even started walking due to the intervention's focus on child engagement and stimulation through play. The *Inshuti z'umuryango* volunteer interventionists have also helped to detect and provide referrals for developmental delays such as in the case of Liliane, a three-year-old. The *Sugira Muryango* interventionist assigned to Liliane's family identified signs of a developmental problem in one of the first sessions with the family and effectively referred them to a higher level of care.

6.2. Mental health and wellbeing

Parents also shared that *Sugira Muryango* had a positive impact on their mental health and wellbeing primarily through the module on stress management. Agnes, a single mother, was suffering from depression and anxiety and was struggling to feed herself and her dependents. The intervention helped her learn to cope with stressors and even inspired her to form a savings group that meets regularly to discuss business ideas and supports each other in the challenges they face as parents. Another single mother named Françoise had been abandoned by her husband and her family and had contemplated taking her own

life. At the end of the intervention, she stated, “The sessions [I] received from the *Sugira Muryango* program completely changed [me] in many different ways. It especially changed [my] thoughts, behaviors and emotions, and [I] became free from stress and the pain of not having someone that could help [me] and talk with [me].” Both Agnes and Françoise also experienced renewed community involvement and social support following the intervention by getting involved in church choirs, which helped them avoid loneliness. The *Sugira Muryango* program also helped by making referrals for parents with mental health concerns requiring further care, such as genocide survivor parents and those with substance use concerns, and by helping them connect to services. This help was especially crucial given that problematic substance use was often one of the factors directly contributing to many of the families’ poverty, such as in the case of Innocent and Chantal mentioned above.

Lastly, the *Sugira Muryango* team has also played a strong advocacy role. For instance, when Josiane, Claude, and their eight children became homeless while enrolled in the intervention due to their house being destroyed by a volcanic eruption in 2021, the *Sugira Muryango* interventionist helped advocate for them with a church project that was helping homeless individuals. In the case of Liliane, who was referred to the hospital for treatment for a developmental delay, the *Sugira Muryango* interventionist advocated for the family throughout the process and was able to get their medical bills covered by government services.

7. Strengths and challenges

Both the *Sugira Muryango* team and families enrolled in the intervention identified multiple strengths in the program’s approach. A major strength has been the program implementation through in-home visits and the use of flexible scheduling. Both of these have increased the intervention’s reach by increasing feasibility for families. The flexible scheduling also allowed for higher levels of engagement from fathers, as sessions are typically scheduled around the father’s availability to allow them to be more involved. Problem solving around father engagement challenges has also often involved the use of father champions or role models to encourage engagement from other fathers, approaches that have been quite successful.

An additional strength of the *Sugira Muryango* program is the significant involvement of government and NGO stakeholders. These stakeholders have been involved from the start in the design and adaptation of the intervention. For instance, in its early stages, the *Sugira Muryango* team collaborated with *Imbuto* foundation to do ECD mapping to identify problems related to ECD in Rwanda. Additionally, the PLAY collaborative approach being used in the expansion of *Sugira Muryango* involves working with a network of ECD stakeholders from the village level all the way to the national level with the involvement of different government agencies such as the National Child Development Agency, the Ministiy of Gender and Family Promotion, the Ministry of Health, and the Ministry of Local Government.

Participants have also expressed an appreciation for the content of the *Sugira Muryango* intervention, starting with the values of humility, avoiding judgment and criticism,

neutrality, active listening, compassion, love, empathy, and respect. Many of the modules from the intervention were cited by participants as having been especially helpful, such as the modules focused on healthy parenting, sharing household responsibilities, the role that every family member plays in child development, the importance of early stimulation, conflict resolution, and stress management. Modules with different relevant actors helped create safe spaces where participants could create a critical consciousness regarding forms of strain and distress in their lives. Yet the version of this consciousness forged through *Sugira Muryango* more resembled a capacity for self-reflexivity also found in Mahr and Campbell's research on Life Wounds Heal workshops in Rwanda, as opposed to a perspective that unmasks oppressive structures of power. In the LWH workshops, enhanced self-awareness made it possible for participants to "acknowledge the wounds of others" and to change their own behaviors in ways that improved "one's mental health and the health of the community" (Mahr and Campbell, 2016: 304). Similarly, through *Sugira Muryango*, participants such as Françoise noted how having others with which to communicate and reflecting on her behavior in relation to others helped change her "thoughts, behaviors and emotions" in a manner that she was better able to cope with everyday life.

Members of the *Sugira Muryango* team explained that the content of the modules gets tailored and customized to meet the needs of each family and focuses foremost on identifying risks of harm (e.g., intimate partner violence, severe malnutrition, untreated illness, etc.) in families to improve safety. After creating this secure foundation, it is often possible for participants to improve their quality of life materially. For example, families reported putting into practice what they learned in the modules on nutrition and hygiene, such as building a kitchen garden to improve access to fresh vegetables and a tippy tap for hand washing. This then created a positive feedback loop, in which improved living standards fortified security and mental wellbeing in the household, which in turn made it possible for families to invest in other forms of material comfort.

Despite these compelling strengths, the implementation of the *Sugira Muryango* intervention has not been without barriers. Some of the main barriers reported by the *Sugira Muryango* team include challenges related to participants moving or relocating mid-intervention. This is due to lack of stability of vulnerable families in *Ubudehe 1* category as they do not own homes and often have to move for work. An additional set of challenges has to do with the *inshuti z'umuryango* volunteer workforce that is used to deliver the intervention. First, as they are a volunteer workforce, there is the issue of competing demands with work as well as other volunteer positions that these interventionists sometimes hold. Moreover, the education level of these volunteers can vary considerably, as some may be trusted members of the community but may not know how to read and write. This creates substantial difficulties in implementing a curriculum-based intervention.

In addition to these implementation barriers, *Sugira Muryango* as an intervention is also not without limitations. For instance, the initiative does not specifically address or even measure parents' genocide exposure, despite the fact that many of the intervention's participants have disclosed their survivor status. This may also be tied to a national government approach that discourages current identification with the categories of "Hutu" and "Tutsi." While this policy is meant to foster a pan-Rwandan identity and discourage divisionism (Moss, 2014),

it may make some Rwandans hesitant to speak openly about their experiences during the genocide. Furthermore, despite growing evidence supporting the link between parenting and intergenerational trauma, the intervention does not currently include an explicit exploration of the impact of changing parenting behaviors on the mental health of children. As the children involved in the intervention grow up, we hope that this will be explored at future follow-up points.

From a structural perspective, *Sugira Muryango* could be criticized for perpetuating biases toward heteronormativity in Global Mental Health, and Global Health more broadly (Pillay et al., 2022). *Sugira Muryango*'s emphasis on "families" and "parenting" defines families according to heteronormative ideals and excludes members of society who fall outside of these boundaries.[2] Those with non-heteronormative identities have often been relatively invisible in Global Health efforts. For example, gender empowerment strategies in South Africa have focused largely on protecting heterosexual women from heterosexual men, systematizing heteropatriarchy while "invisibilising and annihilating the possibility of existence of alternative genders outside these naturalized binaries" (Ndzwayiba and Steyn, 2019: 393). In Rwanda, non-heterosexual sexual identities are highly stigmatized and those who do not conform to heteronormative standards often conceal their identities from healthcare providers (Hughes et al., 2023). An intervention that foregrounds the familial roles of "husbands," "wives," "fathers," and "mothers" in heterosexual marriages fails to question or challenge these disparities.

8. Discussion: lessons for relational healing

In this article, we have described the complexities of healing from trauma and violence in contexts that have experienced one of the most severe forms of relational rupture – genocide. Experiences gleaned from the *Sugira Muryango* and the Victim-Perpetrator Dialogue interventions illustrate how actors looking for opportunities to facilitate recovery in post-genocidal contexts must consider not only ongoing cases of individual mental distress, but also wounds experienced by different forms of collectivities. Following Lester's work on the anthropology of trauma, recovery often means a retethering of the individual to various networks, whether on an interpersonal, familial, communal, or societal level. Trauma is inherently a relational experience.

It is relationships themselves, rather than individual psyches alone, that should be considered as targets of intervention in post-genocidal contexts. In both Cambodia and Rwanda, genocidal violence was catalyzed by extreme visions regarding social reinvention. The Khmer Rouge aimed to remake Cambodia as a communist agrarian society, ridding the nation of foreign influences, higher socio-economic classes, and preexisting forms of collectivity and allegiance such as the family. Meanwhile, in Rwanda, Hutu extremists advocated for the purge of all Tutsi influence from society, which turned neighbors and family members against one another, leading to the elimination of entire family lines and

[2]This framing was less prevalent in the Victim-Perpetrator Dialogue project because the immediate target of the intervention was the relationship between victims and their *direct* perpetrators, as opposed to intra-family relations. Although family members were involved in the reconciliation process, ideals regarding what constituted a "family" and appropriate gender roles were less central to the initiative.

an un precedented number of orphans and widows. Both the Victim-Perpetrator Dialogue Project and *Sugira Muryango* then emerged from broader efforts to catalyze national reconciliation and restore relationships after periods of violent social rupture.

Although the Victim-Perpetrator Dialogue project was designed primarily to address survivor mental health and to reconcile victims with their direct perpetrators, it also had broader implications for relational healing in the communities in which it was enacted. A number of education and reconciliation projects were launched in tandem with the Khmer Rouge tribunal, many of these being psychological services administered by TPO. Although most of TPO's projects framed the concept of perpetration in broad and ambiguous terms, in keeping with the country's approach to reintegration of former Khmers Rouge, the Victim-Perpetrator Dialogue project was something of an anomaly. It dealt specifically with *known* direct perpetrators and their victims. Despite the immense challenges, staff at TPO believed it was an important project to undertake given the psychological strain they had witnessed among victims and perpetrators who lived in close proximity to one another.

In contrast, *Sugira Muryango* was originally envisioned as a parenting intervention that would improve child development outcomes, but because of the specific social configuration of post-genocidal Rwandan society, implementors could not help but confront the legacy of the genocide. *Sugira Muryango* thus became a mechanism for addressing some of this fallout, disrupting maladaptive relationships and parenting behaviors that were often related to parents' own experiences of violence and lingering mental health issues. By improving parents' understanding of early child development and supporting their caregiving and problem-solving skills, *Sugira Muryango* has shown early successes in providing a stronger foundation for Rwanda's youth. The program has encouraged greater involvement of fathers in family affairs and led to improvement in communication and conflict resolution skills. In turn, families report fewer instances of Intimate Partner Violence and better mental health among both children and caregivers.

Both programs also created opportunities to foster different elements of what could be considered "community mental health competence." They helped provide information regarding forms of mental health challenges and possible resources, while creating spaces for critical reflection on the social drivers of distress. As opposed to a kind of "critical consciousness" that focused on oppressive structures of power, spaces for dialogue in both interventions were more likely to cultivate a kind of self-reflexivity that enabled participants to understand their interactions with others and behaviors from new perspectives, often leading to transformations of perceived selfhood and relationships. This shift in emphasis may partly be due to a reluctance to challenge power structures in fragile post-genocidal contexts, where there is ongoing concern about a return to conflict. An openness to transformed identities and relational networks forged possibilities for enhanced social capital. Participants in both programs were simultaneously connected to actors with more resources and able to develop bonds of trust and reciprocity with those of similar social backgrounds.

9. Conclusion

It is important for practitioners to consider not only what is desirable, but also what is *feasible*, especially on a larger scale in low-resource settings. While the Victim-Perpetrator Dialogue project enabled the meaningful restoration of relationships between direct perpetrators and their victims, which also served as a powerful model for their familial and community networks, in many ways it was a resource-intensive intervention. A huge amount of staff time and financial assistance went into reconciling *just two* pairs of victims and perpetrators. Although, like *Sugira Muryango*, the Victim-Perpetrator Dialogue project was characterized by home visits and flexible scheduling, even decades after the genocide, the wounds were still very fresh, and many people simply could not be reconciled with one another. This is why TPO ultimately decided to discontinue the program. In contrast, as an intervention that was not specifically designed to address genocidal recovery, *Sugira Muryango* nonetheless came face-to-face with a number of elements of genocidal fallout stretching across generations. By focusing on present-day behaviors and activities, however, rather than addressing specific violations in the past, the intervention has nonetheless been able to engage large numbers of participants and continue to expand. In addition, *Sugira Muryango* offered other practical benefits for participation, like the dissemination of knowledge related to savings accounts, kitchen gardens, and clean water, which may have served as incentives for participants.

When designing interventions in post-genocidal contexts, practitioners must think carefully not only about ongoing forms of psychological distress, but also about the particular *kinds* of relational rupture that need to be addressed and the most effective mechanisms for doing so. In low-resource settings, very careful consideration must also be given to where funds and human capacity can best be directed to achieve outcomes that can potentially be scaled up and have wider, societal-level impact. The findings from these particular case studies suggest that interventions targeting known perpetrators and specific past crimes will likely have more limited reach than those addressing maladaptive behavioral patterns in current relationships and present-day life struggles.

Acknowledgements

Research reported in this publication was supported by the National Center for Advancing Translational Sciences and the National Institutes of Health under Award Number TL1TR00141 and KL2TR001432. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

References

Adams K, Mann E, Prigal R, Fein A, Sounders T, Gerber B, 1994. Holocaust survivors in a Jewish nursing home. Clin. Gerontol 14 (3), 99–117

Berckmoes LH, Eichelsheim V, Rutayisire T, Richters A, Hola B, 2017. How legacies of genocide are transmitted in the family environment: a qualitative study of two generations in Rwanda. Societies 7, 24. 10.3390/soc7030024.

Betancourt TS, 2022. Understanding longer-term effects of a father-engaged, play-based home visiting intervention to promote early childhood development and prevent violence in Rwanda: the Sugira Muryango longitudinal and spillover study. https://classic.clinicaltrials.gov/ct2/show/NCT05405400?term=NCT05405400&draw=2&rank=1.

Betancourt TS, Farrar J, Placencio-Castro M, Jensen SKG, Brennan RT, 2022. The PLAY Collaborative: Testing an Implementation Strategy for Scaling-Out Evidence-Based ECD+Violence Prevention Home-Visiting in Rwanda. ClinicalTrials.gov. https://classic.clinicaltrials.gov/ProvidedDocs/83/NCT04257383/Prot_001.pdf.

Betancourt TS, Jensen SKG, Barnhart DA, Brennan RT, Murray SM, Yousafzai AK, et al. , 2020. Promoting parent-child relationships and preventing violence via home-visiting: a pre-post cluster randomised trial among Rwandan families linked to social protection programmes. BMC Publ. Health 20, 1. 10.1186/s12889-020-08693-7.

Bijleveld C, Morssinkhof A, Smeulers A, 2009. Counting the countless: rape victimization during the Rwandan genocide. Int. Crim. Justice Rev 19 (2), 208–224. 10.1177/1057567709335391.

Bolton P, 2001. Local perceptions of the mental health effects of the Rwandan genocide. J. Nerv. Ment. Dis 189 (4), 243–248. 10.1097/00005053-200104000-00006. [PubMed: 11339320]

Bonumwezi J, 2022. Mediation of Intergenerational Trauma Transmission by Family Variables in Children of Rwandan Survivors of the 1994 Genocide against the Tutsi. Doctoral dissertation, Montclair State University. Retrieved from. https://digitalcommons.montclair.edu/etd/1056/.

Brounéus K, 2008. Truth-telling as talking cure? Insecurity and retraumatization in the Rwandan Gacaca court, 39 (1), 55–76. 10.1177/0967010607086823.

Bruhn J, 2009. The Group Effect: Social Cohesion and Health Outcomes. Springer-Verlag, New York.

Campbell C, Burgess R, 2012. The role of communities in advancing the goals of the Movement for Global Mental Health. Transcult. Psychiatr 49 (3–4), 379–395. 10.1177/1363461512454643.

Denov M, 2015. Children born of wartime rape: the intergenerational realities of sexual violence and abuse. Ethics, Medicine and Public Health 1 (1), 61–68. 10.1016/j.jemep.2015.02.001.

Der Sarkissian A, Sharkey JD, 2021. Transgenerational trauma and mental health needs among Armenian genocide descendants. Int. J. Environ. Res. Publ. Health 18 (19), 10554. 10.3390/ijerph181910554.

Dyregrov A, Gupta L, Gjestad R, Mukanoheli E, 2000. Trauma exposure and psychological reactions to genocide among Rwandan children. J. Trauma Stress 13 (1), 3–21. 10.1023/a:1007759112499. [PubMed: 10761171]

Fein H, 1993. Genocide: A Sociological Perspective. University of Michigan, Ann Arbor.

Fenig S, Levav I, 1991. Demoralization and social supports among Holocaust survivors. J. Nerv. Ment. Dis 179, 167–172. 10.1097/00005053-199103000-00010. [PubMed: 1997666]

Field N, Muong S, Sochanvimean V, 2013. Parental styles in the intergenerational transmission of trauma stemming from the Khmer Rouge regime in Cambodia. Am. J. Orthopsychiatry 83 (4), 483–494. 10.1111/ajop.12057. [PubMed: 24164520]

Fonesca L, Jovchelovitch S, 2023. The Long Hard Road of Reconciliation: prefiguring cultures of peace through the transformation of representations of former combatants and identities of urban youth in Colombia. Eur. J. Soc. Psychol 54 (1), 1–16. 10.1002/ejsp.2967.

Fujii L, 2011. Killing Neighbors - Webs of Violence in Rwanda. Cornell University Press, Ithaca.

Garry S, Checchi F, 2020. Armed conflict and public health: into the 21st century. J. Public Health 42 (3), e287–e298. 10.1093/pubmed/fdz095.

Giladi L, Bell TS, 2012. Protective factors for intergenerational transmission of trauma among second and third generation Holocaust survivors. Psychological Trauma: Theory, Research, Practice, and Policy. 10.1037/a0028455.

Gishoma D, Brackelaire JL, Munyandamutsa N, Mujawayezu J, Mohand AA, Kayiteshonga Y, 2014. Supportive-expressive group therapy for people experiencing collective traumatic crisis during the genocide commemoration period in Rwanda: impact and implications. J. Soc. Polit. Psychol 2, 469–488. 10.5964/jspp.v2i1.292.

Hinton A, 1998. Why did you Kill? The Cambodian Genocide and the dark side of face and honor. J. Asian Stud 57 (1), 93–122. 10.2307/2659025.

Hughes T, Riggle E, Moreland P, White R, Gishoma D, Galupo P, 2023. Trauma, mental health, and health care experiences of lesbian and bisexual women in Rwanda. Psychology of Sexual Orientation and Gender Diversity 10 (1), 34–43. 10.1037/sgd0000417.

Ingabire CM, Kagoyire G, Habarugira N, Rutayisire T, Richters A, 2022. They tell us little and we end up being confused: parent–child communication on familial experiences of genocide and its aftermath in Rwanda. Transcult. Psychiatr 59 (3), 349–361. 10.1177/13634615221078483.

Jensen SKG, Sezibera V, Murray SM, Brennan RT, Betancourt TS, 2021. Intergenerational impacts of trauma and hardship through parenting. JCPP (J. Child Psychol. Psychiatry) 62 (8), 989–999. 10.1111/jcpp.13359. [PubMed: 33284991]

Kahn S, Denov M, 2019. We are children like others: pathways to mental health and healing for children born of genocidal rape in Rwanda. Transcult. Psychiatr 56 (3), 510–528. 10.1177/1363461519825683.

Kahn S, Denov M, 2022. Transgenerational trauma in Rwandan genocidal rape survivors and their children: a culturally enhanced bioecological approach. Transcult. Psychiatr 1–13. 10.1177/13634615221080231.

Kayiteshonga Y, Sezibera V, Mugabo L, Iyamuremye JD, 2022. Prevalence of mental disorders, associated co-morbidities, health care knowledge and service utilization in Rwanda – towards a blueprint for promoting mental health care services in low- and middle-income countries? BMC Publ. Health 22 (1), 1858. 10.1186/s12889-022-14165-x.

Lesley E, 2022. Testimony as Transformation: Resilience, Regeneration and Moral Action through Spiritually-Adapted Narrative Therapy in Cambodia. Emory University, USA. PhD Dissertation.

Lesley E, 2021. Lessons for the Future: Khmer Rouge survivor testimonies as sites of individual and social regeneration. Ethnos 86 (3), 570–591. 10.1080/00141844.2019.1681487.

Lesley E, 2014. Memory at the site: witnessing, education and the repurposing of Tuol Sleng and Choeung Ek in Cambodia. In: Eltringham N, Maclean P (Eds.), Remembering Genocide. Routledge, London, pp. 131–151.

Lester R, 2013. Back from the edge of existence: a critical anthropology of trauma. Transcult. Psychiatr 50 (5), 753–762. 10.1177/1363461513504520.

Lordos A, Iouannou M, Rutembesa E, Christoforou S, Anastasiou E, Bjorgvinsoon T, 2021. Societal healing in Rwanda: toward a multisystemic framework for mental health, social cohesion and sustainable livelihoods among survivors and perpetrators of the Genocide against the Tutsi. Health and Human Rights 23 (1), 105–118. [PubMed: 34194205]

Mahr IL, Campbell C, 2016. Twenty Years Post-Genocide: the creation of Mental Health Competence among Rwandan survivors through community-based healing workshops. J. Community Appl. Soc. Psychol 26 (4), 291–306. 10.1002/casp.2263.

Mamdani M, 2001. When Victims Become Killers: Colonialism, Nativism and the Genocide in Rwanda. Princeton University Press, Princeton.

Miller KE, Rasmussen A, 2017. The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. Epidemiol. Psychiatr. Sci 26 (2), 129–138. 10.1017/S2045796016000172. [PubMed: 27040595]

Mollica R, Brooks R, Tor S, Lopes-Cardozo B, Silove D, 2014. The enduring mental health impact of mass violence: a community comparison study of Cambodia civilians living in Cambodia and Thailand. Int. J. Soc. Psychiatr 60 (1), 6–20. 10.1177/0020764012471597.

Moss SM, 2014. Beyond conflict and spoilt identities: how Rwandan leaders justify a single recategorization model for post-conflict reconciliation. J. Soc. Polit. Psychol 2 (1), 435–449. 10.5964/jspp.v2i1.291.

Nadler A, Sokal M, 2001. The victim and the psychologist: changing perceptions of Israeli Holocaust survivors by the mental health community in the past 50 Years. Hist. Psychol 4 (2), 159–181. 10.1037/1093-4510.4.2.159.

National Institute of Statistics of Rwanda, 2008. Recensement des rescapés du génocide de 1994: Rapport final, http://statistics.gov.rw/publication/genocide-survivors-census-report-2007.

Ndzwayiba N, Steyn M, 2019. The deadly elasticity of heteronormative assumptions in South African organizations. Int. J. Social Econ 46 (3), 393–409. 10.1108/IJSE-11-2017-0552.

Ng LC, Ahishakiye N, Miller DE, Meyerowitz BE, 2015. Life after genocide: mental health, education, and social support of orphaned survivors. International Perspectives in Psychology: Research, Practice, Consultation. 4 (2), 83–97. 10.1037/ipp0000031. [PubMed: 26236560]

Path K, 2015. Multivocal resistance to transitional justice in post-genocide Cambodia. In: Jones B, Bernath J (Eds.), Resistance and Transitional Justice. Routledge, London, pp. 133–151.

Pham PN, Weinstein HM, Longman T, 2004. Trauma and PTSD symptoms in Rwanda. JAMA 292 (5), 602. 10.1001/jama.292.5.602. [PubMed: 15292086]

Pillay S, Ntetmen J, Nel J, 2022. Queerin Global Health: an urgent call for LGBT+ affirmative practices. Lancet Global Health 10 (4), e574–e578. 10.1016/S2214-109X(22)00001-8. [PubMed: 35176236]

Rehm J, Shield KD, 2019. Global burden of disease and the impact of mental and addictive disorders. Curr. Psychiatr. Rep 21 (2), 10. 10.1007/si1920-019-0997-0.

République du Rwanda, 2004. Dénombrement des victimes du génocide, https://cnlg.gov.rw/fileadmin/templates/Publications/denombrement_des_victimes_du_genocide_perpetre_contre_les_tutsi_avril_2004.pdf.

Richters JM, Rutayisire T, Dekker C, 2010. Care as a turning point in sociotherapy: remaking the moral world in post-genocide Rwanda. Medische Antropologie 22, 93–108.

Rieder H, Elbert T, 2013. Rwanda – lasting imprints of a genocide: trauma, mental health and psychosocial conditions in survivors, former prisoners and their children. Conflict Health 7, 1. 10.1186/1752-1505-7-6. [PubMed: 23339463]

Rowland-Klein D, Dunlop R, 1998. The transmission of trauma across generations: identification with parental trauma in children of Holocaust survivors. Aust. N. Z. J. Psychiatr 32 (3), 358–369. 10.3109/00048679809065528.

Rutikanga C, 2019. A social work analysis of home-grown solutions and poverty reduction in Rwanda: the traditional approach of ubudehe. In: Twikirize JM, Spitzer H (Eds.), Social Work Practice in Africa: Indigenous and Innovative Approaches. Fountain Publishers, Kampala, pp. 61–80.

Schaal S, Elbert T, 2006. Ten years after the genocide: trauma confrontation and posttraumatic stress in Rwandan adolescents. J. Trauma Stress 19 (1), 95–105. 10.1002/jts.20104. [PubMed: 16568463]

Shrira A, Mollov B, Mudahogora C, 2019. Complex PTSD and intergenerational transmission of distress and resilience among Tutsi genocide survivors and their offspring: a preliminary report. Psychiatr. Res 271, 121–123. 10.1016/j.psychres.2018.11.040.

Thomson D, Rich M, Kaigamba F, Socci A, Hakizamungu M, Bagiruwigize E, Binagwaho A, Franke M, 2014. Community-based accompaniment and psychosocial health outcomes in HIV-infected adults in Rwanda: A prospective study. AIDS Behav. 18 (2), 368–380. 10.1007/s10461-013-0431-2. [PubMed: 23443977]

United Nations Children's Fund Rwanda, 2018. Situation analysis of children in Rwanda: summary report. https://www.unicef.org/rwanda/media/391/file/Situation-Analysis-of-Children-in-Rwanda-Summary.pdf.

United Nations Children's Fund Rwanda, 2021. Care reform in Rwanda: a virtual study tour. https://www.unicef.org/esa/media/10991/file/Care-Reform-Rwanda-2021.pdf.

United Nations High Commissioner for Refugees, 2021. Global Trends Report. UNHCR Global Data Service, https://www.unhcr.org/media/40152. (Accessed 5 June 2023).

Uwizeye G, Thayer ZM, DeVon HA, McCreary LL, McDade TW, Mukamana D, Park C, Patil CL, Rutherford JN, 2021. Double Jeopardy: young adult mental and physical health outcomes following conception via genocidal rape during the 1994 genocide against the Tutsi in Rwanda. Soc. Sci. Med. 278, 113938 10.1016/j.socscimed.2021.1139. [PubMed: 33905987]

Williamson Sinalo C, Irakoze PC, Veale A, 2020. Disclosure of genocide experiences in Rwandan families: private and public sources of information and child outcomes. Peace Conflict: Journal of Peace Psychology 27 (4), 642–653. 10.1037/pac0000521.