



# Everyday partner violence in Rwanda: The contribution of community-based sociotherapy to peaceful family life

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## ABSTRACT

*Rwanda is well known for the 1994 genocide against the Tutsi. What is less known is the increase in everyday partner violence that has come about as a legacy not only from the genocide but also from the war preceding the genocide. A range of war and genocide-related factors continue to contribute to family conflict and intimate partner violence in Rwanda to this day. This raises particular challenges for interventions aimed at curbing such incidences. This article presents arguments for community-based sociotherapy as a psychosocial approach that can effectively meet these challenges. The qualitative study that informed the article was situated in the north of Rwanda. Data collection methods included interviews, focus group discussions, participant observation and informal conversations. Data were coded and categorised in relation to the main research questions. Social disconnection and mistrust as legacies of the war and genocide proved to be major issues underlying family conflict and partner violence. Sociotherapy reportedly restores trust, dignity, respect and a caring attitude among its participants, thereby facilitating the creation of a home environment in which husband and wife start to openly address their problems, cease different forms of partner violence, raise their standard of living and become role models in their neighbourhood. Community-based sociotherapy as a grassroots intervention has proven to be an effective complement to more top-down public and political responses to gender-based violence.*

**Keywords:** *partner violence, family conflict, community-based sociotherapy, war, genocide, Rwanda.*

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## INTRODUCTION

In the international literature about brutal violence against women, frequent reference is made to the mass rape of women that took place during the 1994 genocide against the Tutsi in Rwanda (Human Rights Watch, 1996). Less documented are the various direct and indirect consequences of these rapes for women's lives (Richters & Kagoyire, 2014). Even less attention has been paid to the ongoing and increasing incidence of everyday partner violence against women as well as men, not only as an after- effect of the genocide but also of the preceding war.

In a large national household survey among 1 311 men and 2 301 women on perceptions of masculinity and the problem of gender-based violence in Rwanda, more than half of the women responded as having experienced gender-based violence committed by a partner. Cross-analyses indicate that men who went through the war and/or genocide tend to become violent towards their partners more often than men who were not involved in the war (Slegel & Kimonyo, 2010). The survey did not examine the details of men's war and genocide experiences that may have contributed to their violent behaviour. In a cross-sectional study conducted in the north of Rwanda by Verduin, Engelhard, Rutayisire, Stronks and Scholte (2013) on intimate partner violence among 241 married men and women, 25% of the respondents reported having been involved in such violence in the preceding three months. Seventeen percent of men and 29,7% of women indicated that they were victims of intimate partner violence. A minority of men and women reported being both victims and perpetrators. No women indicated being perpetrators only. Five men reported being perpetrators only, and two men reported being a victim of intimate partner violence without being perpetrators themselves. These results demonstrate that both men and women can be victims as well as perpetrators of intimate partner violence and that in some cases the violence is bidirectional. Study findings suggest that the reported violence is associated with common mental health disorders and suicidal ideation, while perpetrators may suffer from mental health problems as much as, or even more than, victims. Whether the study outcomes could be empirically related to the past war and genocide violence was beyond the scope of the study.

All 241 respondents in the Verduin et al. (2013) study also participated in a larger study about the effects of a psychosocial intervention – community-based sociotherapy – on survivors of mass violence in Rwanda (Scholte et al., 2011). The study found that sociotherapy caused lasting improvements in participants' mental health. In our study we will demonstrate that this improvement in mental health is inextricably linked to other effects. Sociotherapy is a multi-systemic intervention which has multi-systemic effects.

The qualitative study that informed this article was, like the studies of Verduin et al. (2013) and Scholte et al. (2011), conducted in the Gicumbi district in the northern province of Rwanda. Complementary to these two previous studies, it focused on the causal linkages between war and genocide experiences and current everyday partner violence, as well as the contribution that community-based sociotherapy has made in terms of putting an end to such violence.

## **SOCIOTHERAPY IN A POST-CONFLICT SETTING**

Between 1990 and 1994 the population in the north of Rwanda suffered significantly, both from the war between the then Hutu-dominated government and the opposition Tutsi-dominated Rwandan Patriotic Front (RPF), and then the subsequent genocide against the Tutsi. The war violence led to the mass displacement of people to places of shelter further south and to refugee camps in adjacent countries. The experiences of those who became internally displaced or exiled abroad were often quite traumatic. Exile was the continuation of war by other means. Living conditions in and around displacement camps were very harsh, particularly in the highly militarised camps in the Democratic Republic of Congo, with the result that thousands of people died of hunger, disease, and direct violence (Prunier, 2009).

After the genocide, most displaced and exiled people gradually returned to their place of origin. There, many found most of their properties destroyed. The population, whether or not they had been displaced or had gone into exile, had to cope with the loss of loved ones and a society that had to rebuild itself in all aspects. A widespread feeling of insecurity, powerlessness and desperation affected community and family life deeply. Many people no longer cared for themselves, having lost interest in their own sense of dignity or future. Some became aggressive in reaction to just about anything, good or bad. Others wandered aimlessly around without courage or a plan to survive. In short, after a decade of so-called peace the Byumba population was still much affected by the legacy of a history of political violence.

In order to help redress this situation, in 2005 the Byumba Diocese of the Anglican Church of Rwanda introduced community-based sociotherapy in its constituency, which included Gicumbi (Richters, 2010; Richters, Dekker & Scholte, 2008). The major objectives were to foster feelings of dignity, safety and trust in all survivors of the war and genocide (regardless of religion and ethnicity), to reduce mental and social distress, and to overcome disturbed and delayed socio-economic development. The Byumba Diocese had been trying to reach these objectives since its foundation in 1991 through individual pastoral counselling and socio-economic development projects, but had felt overwhelmed by the requests for

support. It realised that new approaches were required to address the psychosocial needs of the population more effectively. Sociotherapy was seen as an approach worth trying.

Sociotherapy in Rwanda, as a context-driven multi-systemic or ecological intervention (cf. Hamber, 2009; Stanciu & Rogers, 2011; Walsh, 2007), turned out to be a viable alternative to the many individual oriented trauma counselling initiatives in the country. In Byumba, like in other post-war and post-genocide settings, the past multiple traumatic violence-related events had had an impact as much on the physical and mental level as on the social and cultural level. The social psychologist Martín-Baró (1989) introduced the term “psychosocial trauma” in reference to such multi-systemic traumatising. While psychic trauma refers to a particular injury that difficult or exceptional experiences may inflict on a particular person, social trauma refers to a whole population being affected by a historic process such as war. This does not imply that a uniform effect of war is produced throughout a population; each individual has his or her particular experiences of traumatic loss. However, Martín-Baró (1989) argues that we need to understand the human being as “a product of a particular history, which in each case is manifested in the social relations of which the individual is an active and passive part” (p. 16). This implies that, for the purpose of reaching the objectives set by sociotherapy in Byumba, understanding people’s collective history is as important as understanding their individual history.

Sociotherapy in Rwanda uses the group as a therapeutic medium to establish trust, create an open environment for discussion and form peer support structures. Groups of ten to fifteen people – the majority of whom are village people with little or no education – meet weekly for approximately three hours over a period of fifteen weeks, in participants’ direct living environment, in a place that they experience as safe. Two trained sociotherapists guide the group through the subsequent phases of safety, trust, care, respect, new rules and memories. Throughout the journey, seven principles are applied: interest, equality, democracy, participation, responsibility, learning by doing, and the here and now (Richters et al., 2008).

As described elsewhere (Richters, Rutayisire & Dekker, 2010), it is in the sociotherapy phase of care that the healing of people’s social and individual distress starts to take effect. When a person understands that he or she is safe and can trust the other group members, that person usually starts to share his or her everyday troubles with them. Group participants are encouraged to take care of one another and attempt to solve their daily problems together. This process enables participants to think about the future constructively once again and to change their behaviour accordingly. In contrast to many other healing and reconciliation programmes in Rwanda, confrontation with painful memories about the past is not encouraged. The main focus is on actual daily life problems, including, for instance,

poverty issues, family conflicts, health issues, drug abuse, distrust among neighbours and social isolation. In general, it is only towards the end of the group sessions, when a genuine atmosphere of trust and mutual respect has been established, that painful memories of the past are shared.

The Byumba sociotherapy programme started with so-called single category groups composed of, for instance, widows, people affected by HIV and AIDS, single mothers, former prisoners, secondary school students, men living in difficult home situations and elderly people. Through monitoring and evaluation, it soon became clear that within all of these groups, family problems were a much discussed topic. This resulted in the establishment of sociotherapy groups for either women or men in conflict with their spouse, as well as groups for married couples. Over the seven years that the programme was in operation, at least 10,000 people participated in a sociotherapy group, and altogether 120 sociotherapists contributed to the facilitation of these groups.

## **STUDY APPROACH**

The empirical data were collected by Sarabwe, the second author, who has lived for most of his life in Gicumbi and served on the Byumba sociotherapy programme as a staff member throughout the years in which it was in operation (2005–2012). He witnessed many family conflicts in his living environment related to the effects of the war and genocide, and also became familiar with the high incidence of family conflict as an issue presented and discussed in sociotherapy groups. This made him decide to focus his research for his MA in social work on an exploration of the ways in which the war and genocide have affected couples' lives and relationships, and the role that sociotherapy has played in solving family conflicts in the Gicumbi district. Richters, the first author, has accompanied the sociotherapy programme in Byumba throughout, which familiarised her with the issues addressed in this article and enabled her to put them into perspective.

The study location covered three sectors (administrative entities) in the Gicumbi district. Data collection took place during the first six months of 2012. The main researcher used reports by sociotherapists documenting sociotherapy group sessions for the identification of groups in which family conflicts were a frequently-addressed issue. Based on people's availability, and on participants' testimonies of significant changes experienced due to sociotherapy presented in closing sessions of sociotherapy groups, he selected six sociotherapy participants and six so-called indirect participants (spouses of sociotherapy participants) to contribute to the study as key informants. Six sociotherapists familiar with facilitating sociotherapy groups for men or women in conflict with their spouses and three local leaders familiar with the impact of sociotherapy in their working area were selected for

the same purpose. A semi-structured interview of approximately one hour was conducted with each of the 21 key informants (12 women and nine men). Three focus groups were organised: one with the six direct participants, one with the six indirect participants and one with the six sociotherapists. In addition, the researcher participated in sociotherapy group sessions as an observer, as well as in the everyday life settings of group participants and their spouses through informal conversations and observation.

This multi-method approach helped to improve the validity of the data. All interviews and focus group discussions were audio-recorded and transcribed. Data were coded and categorised in relation to the two main research questions: What are the most significant war and genocide-related factors contributing to everyday family conflict? And what are the most significant changes contributing to stability and peace in families as a result of participation in sociotherapy? Being a local person helped the researcher to understand the difficulties that some informants had in sharing family secrets with him and in going back in their thoughts to a traumatising past. It also contributed to overcoming these difficulties. He gained the confidence of his informants by convincing them that the information that they would share with him would be anonymous and thus confidential; the names of informants in this article are pseudonyms.

## **FAMILY CONFLICT AND ITS CONTRIBUTING FACTORS**

Informants agreed that the ideal family is one in which husband and wife love, respect, trust and help each other, share the bad and the good, develop visions and plans together, consult one another over resource allocation, jointly carry out family responsibilities, are both economically productive, agree on the desired number of children, are faithful to one another, and advise each other. The examples that informants gave of factors that divert couples away from this ideal were gender-specific. As sources of conflict, men referred to wives not respecting them, not responding to their requests, not caring for the children, and not welcoming visitors in an appropriate way. Women mostly referred to men not understanding their worries, not providing for the family and misusing resources, and beating and insulting them.

Our informants also provided information on war and genocide-related factors that have contributed to the current high prevalence of disturbances in family relationships. All were topics of debate in focus group discussions and featured in sociotherapy group sessions. Although we are unable to unpack these in much detail given the focus of this particular paper, the factors identified are noteworthy and include: poverty as an all-determining issue; the death of important others; family planning issues related to the loss of children; separation from loved ones; being physically disfigured and/or disabled; the care of

orphans; interethnic marriage; increased incidence of polygamy and extramarital sex; disease (specifically HIV and AIDS) and injury; disparate church membership; and women's empowerment due to survival skills learned during the war and genocide. A number of these issues intersected with one another. An overall crosscutting factor was mistrust. All together, the factors identified provided us with the contours of a collective history of family conflict due to war and genocide. It is important to note that our informants mostly used the words "war" and "genocide" concurrently, because in their experience both forms of political violence were blended together. This made it difficult for them to determine clearly which aspects of their deteriorated life situation could be attributed to war and which to genocide.

The main researcher did not pose direct questions about violence perpetrated specifically by women. This issue was, however, occasionally discussed in sociotherapy groups; for instance, in response to the question of why men are violent, it was mentioned that men's violence is a reaction to the violence perpetrated by their wives. The researcher observed two male participants sharing in group sessions that their wives had been jailed because of misuse of family resources, drug abuse and in one case also because of an attempt on his life. Usually, however, men would rather be silent about the violence perpetrated by their spouses against them in order to maintain their sense of masculinity.

## **THE CONTRIBUTION OF SOCIO THERAPY TO THE REDUCTION OF PARTNER VIOLENCE**

Sociotherapy helps group participants to overcome the obstacles that prevent them from living a peaceful and relatively prosperous family life. Through dialogue and action within a sociotherapy group, many participants start to break through the confines of their "limit-situation" (a situation that impedes a person's full humanisation) (Moane, 2003, p. 97), which soon has a positive spin-off effect on their families and communities.

## **JOURNEYING THROUGH THE SOCIO THERAPY PHASES**

Distrust and feelings of insecurity, as indicated above, are legacies of the war/genocide that pervade the life of many people in Gicumbi. The aim of sociotherapy is, first of all, to establish a certain degree of safety and trust in a sociotherapy group. Participants are warmly welcomed in the group. They are asked to sit in a circle, which symbolises the principle of equality that starts to make participants feel valued and dignified. In the phase of safety, they begin to share the stressors that make each one of them feel insecure. They then prioritise their problems in a democratic fashion according to the severity of the stress that they cause, and subsequently discuss them in a respectful way in the prioritised order.

"After the phase of trust, group participants start to value each other and recognise that each person has strengths and weaknesses, which [in couples] should be

tolerated by the partner in order to live harmoniously. Each one becomes aware that one can make a mistake and should apologise for it, while one also learns to forgive.” (Ange, sociotherapist, aged 52, focus group discussion)

Once safety and trust are established, participants may speak more freely about what is most at stake for them. The experience of being listened to strengthens the feeling of being valued once again, and usually makes people receive the subsequent advice of others in good faith. As Aline (female sociotherapy participant, aged 38) testified,

“having a voice and being heard by twelve participants and two sociotherapists who paid attention to my problem, I felt that today I am a person with value and dignity.”

During the phase of care, participants share what care means to them. Care is subsequently enacted through, for instance, visiting each other and assisting those who are disabled in agricultural activities. Many participants have suffered from stigmatisation and discrimination, while at the same time they stigmatise and discriminate against others. They have also stigmatised themselves by internalising society’s non-recognition of their value and dignity. Home visits, group work, and assisting each other contribute further to making participants feel recognised and respected once again. Being heard, visited, and advised shows and reassures participants that they are still human beings who are not only being taken care of, but can also take care of others.

Each idea brought forward in the group as advice to others is valued, respected, and appreciated, at least during the first number of group sessions (see below). This way, participants develop feelings of pride and efficacy over having contributed to problem-solving for their peers. This pride gives them the power to approach their own partner and solve problems at home. Gradually, they also develop new rules (see below), which they apply for the sake of positive change.

## **LESSONS LEARNED IN SOCIO THERAPY APPLIED AT HOME AND IN THE COMMUNITY**

Soon, participants begin to apply what they have learned in sociotherapy at home. Feeling like human beings again contributes to thinking and acting objectively in family life, which in turn reduces tension and dissatisfaction. Through the experience of care, each spouse starts to feel responsible for helping their partner live peacefully and enjoy family life. Ancilla (female sociotherapy participant, aged 42) narrated in an interview:

“Before the genocide, my husband considered me to be someone without any useful ideas. That was why I considered him a foolish and useless man. After the

war/genocide, when the number of widows drastically increased, he was not only using family resources for drinking but also for buying gifts for widows with whom he wished to have sex. This was stressing me much, because in addition to poverty I suffered from the risk of getting sexually transmittable diseases, including HIV/AIDS. In sociotherapy, I learned that even if my husband is behaving wrongly, he is still my husband, deserving respect. I started to show him love and respect even when he was drunk. In the mornings, I was greeting him and finding him something to eat, because many times he did not eat in the evening when he was drunk. He started to recognise me as a powerful and compassionate woman. In addition, he started to pay attention to my ideas and changed the drinking and infidelity behaviour.”

Ancilla did not ask anything from her husband and did not give him any advice. She merely changed her own behaviour. One of the results was that his misuse of their financial resources, earned through his work in a tea plantation, ceased.

“What surprised me was that my husband by himself decided to pay for my contribution to the association I belong to, without me requesting it” (Ancilla).

Hakuzimana (female sociotherapy participant, aged 32) gave a similar testimony:

“Before participating in sociotherapy sessions, my husband was using almost all family resources to buy beer, resulting in daily beatings. Up to today, I still suffer from their effects. In the evenings, I was always prepared to fight. While participating in sociotherapy, the participants told me that peace is not always achieved by preparing for war but more through doing good things that might change the opponent. At home, I prepared very delicious food that, with joy and pride, I invited my husband to share when he was being tempted to insult and beat me. He only took a small quantity to eat because he first wanted to know where the respectful behaviour and care I showed came from. After preparing this food three times, he drastically reduced his disputes with me and we started to share family issues with each other as he learned that I was participating in sociotherapy sessions. He now helps me in digging, feeding domestic animals, and other activities, which before I used to perform alone.”

Couples in which one of the partners has participated in sociotherapy learn to respect each other, to value and care for each other, to feel equal, and to identify that each has contributed in his or her own way to insecure situations and conflict. They learn to be calm when conflict arises, to reduce outrageous behaviour and to create opportunities for

negotiation. Subsequently, they explore alternative strategies together and solve problems progressively. This is illustrated by what Evariste narrated in an interview:

“Since marriage [in 1992], I [a Hutu man] was living well with my wife, a Tutsi woman, fostering children born from her first husband [a Tutsi] who had already died in 1988. Our peaceful family life changed after 1994. During the genocide, my wife Mukakamari lost almost all family members, while I had already lost some during the war. My family and neighbours in Gicumbi were not happy to see me living with a Tutsi survivor with two children, while my wife was asking herself how to live with a Hutu whom she associates with the genocide perpetrators. This situation widened the distance in our relationship, even though we together received three children. Soon I started to hear neighbours advising me not to live with an old Tutsi woman [aged 57]. This raised a dilemma in me: should I remain with her or find another wife?”

Evariste and Mukakamari faced problems commonly found in interethnic marriages. Children born in a family like Evariste’s are perceived as Hutu (after their father, who is Hutu), while the children from Mukakamari’s previous husband that she brought into the marriage are seen as fully Tutsi (since their father was Tutsi). This ethnic difference may lead to conflict between both the children and the parents over, for instance, the historical education of the children and the sharing of property between them. This happened in Evariste’s family. Due to Mukakamari’s participation in sociotherapy, however, the situation changed for the better. When Mukakamari came home after the third sociotherapy session, she politely greeted her husband, cooked for him, and painfully attempted to smile. During the following week, she started to tell him what she was learning in sociotherapy and went to dig together with him, sharing some joyful words. Gradually, they both opened up and discussed their family problems due to ethnicity, the way that they affected their family life, the children’s education and the community as a whole. They then spoke to their children about Rwanda’s history of ethnic conflict and the ways in which they had both suffered from it. The end result was the restoration of peace in their family.

Group members also regulate one another’s practices outside of the group by checking on whether they are applying sociotherapy’s informal code of conduct, which requires them to become model families in their respective communities. Aline (female sociotherapy participant, aged 38; her husband participated in another sociotherapy group) testified in an interview:

“Before participating in sociotherapy, I could not share a blanket with my husband in bed. He was lying on a small mattress while I was lying on grasses. He wanted

me only near him for sex. The fact that he would also force me to have sex with him at the place where I was digging harmed me a lot. I was wondering how long I should remain in this awful family life. The food he bought he consumed alone. After participating in sociotherapy, my husband became like a Christian who fears that God knows everything one thinks. This resulted in family sharing and consultation, even in matters of sexual intercourse. He fears that he may behave wrongly and that others or I might notice it if he would. Those who participated in sociotherapy with him would certainly accuse him of misrepresenting the behaviour promoted by sociotherapy, and those who did not participate would ask themselves why a person who participated in sociotherapy would behave like that. My husband really became a trustworthy person. If my husband comes home and tells me that he has bought goods on credit, and personally decides to explain to me the reason why he did it and considers my corrective advice, how can I not trust him in matters of family financial management?"

When a family belonging to Aline's church experiences conflict, the church leaders refer that family to Aline for guidance; they know that she can help as she was able to manage a conflict in her own family that was considered by the community to be a most difficult conflict to solve.

Participants experience that in sociotherapy, taken-for-granted rules are not always the best and that change for the better is possible. At the start of a cycle of fifteen sociotherapy sessions, group members are given the opportunity to set rules democratically that will guide them during their sociotherapy process. Examples of such rules are not being late, not interrupting the person who is speaking and not judging an idea brought forward in the group as right or wrong. In later sessions, participants evaluate the usefulness of these rules and, based on their experience in the group and new understandings, might remove ineffective rules and replace them by entirely new rules if appropriate. For instance, while it is necessary at the start that everyone's idea is valued as worthwhile, later on one can and should accept that, based on good arguments, one's idea might be rejected. So the rule of not judging ideas as right or wrong is no longer necessary. Participants subsequently look at their families and communities with the understanding that things could be done differently from what is customary. They start to analyse the value of the taken-for-granted rules that families and communities apply and explore how these rules could be revised for the sake of smooth and peaceful progress for families and communities. As Hakuzimana said,

"We as sociotherapy graduates have to create new rules in the family and community, just as we do in sociotherapy in the new rules phase."

## LESSONS LEARNED ABOUT GENDER BALANCE AND WOMEN'S RIGHTS

Already during the phase of safety, gender issues, such as those identified above, are presented by women in the group. Before this, many women feel very isolated in dealing with these issues, but during the sessions they gradually start to share the rights and obligations that they have and advise one another on how to enjoy them. In becoming more aware of their rights, women start to claim them strategically, peacefully and lovingly. The sociotherapy principle of responsibility motivates them to be active in problem-solving and engaging in activities that increase the family income, such as enrolling in income-generating associations. This overcoming of passivity in family affairs motivates men to value their wives more than before.

Evariste's change in behaviour is exemplary of what sociotherapy can achieve in terms of gender balance. When he arrived one-and-a-half hours late for a scheduled interview, he apologised to the researcher by saying that he first had to attend to his responsibilities at home, such as searching for grass to feed the family cow and cooking food for the children while his wife had gone to church. Later in the interview, he stated that in his family there are no specific tasks for the husband or wife to carry out; there are only family tasks. Evariste confirmed that he and his wife openly shared all their views and sadness. Neither of them could spend more than one thousand Rwandan francs (a little over one Euro) at a time without informing the other. They had agreed to buy land and were saving money in the bank for that purpose. Both were informed about their bank account balance. Another significant change was made by Semana (male sociotherapy participant, aged 37), which he discussed during the group's closing session. Upon completing the sociotherapy sessions and after discussion with his wife, Semana underwent a vasectomy, an action which goes against the general perception among the population that family planning is entirely a woman's responsibility. This is significant since disagreements over family planning are one of the main factors contributing to the increase of family conflict in the post-war/genocide period.

Respect for women's rights and an increase in gender balance have also contributed to small-scale economic developments, as some of the quotations above have already shown. Sociotherapy teaches spouses to take equal responsibility for income-generating activities. Furthermore, when men start to realise that their wives are carrying the family burden alone, they are challenged to support them. Two more testimonies of female sociotherapy participants illustrate its positive results:

"From daily fights with my husband due to poverty and disagreements over resource management, I tried to commit suicide. Fortunately, my children saw me hanging and

saved me. After being rescued, I joined sociotherapy, where I learned that poverty can be ended or reduced by working hard, collaborating, mutual understanding and forgiveness among family members. With the income I got from the association I recently joined, and by properly using the family land, we have reduced the poverty at home and my family has peace.” (Jeanne, aged 33)

“After participating in sociotherapy, I learnt about my responsibility in the family’s economic improvement. When my family got a goat from Ubudehe [the government programme supporting poor people to increase their income], I advised my husband not to sell it and we now have five goats, while other families who benefited from the goat project sold their goats for beer.” (Merisiyana, aged 38, victim of rape, HIV positive)

## DISCUSSION

Our study has identified several war/genocide-related factors that contribute to gender-based violence in the north of Rwanda, which should be taken into account in prevention programmes. These factors intersect with traditional cultural norms, values and practices that sustain perceptions of masculinity and femininity and continue to contribute to gender inequalities and gender-based violence. At the same time, traditional gender relations are under strain as a result of altered social realities after the genocide. In the post-conflict situation women have had to take on more responsibilities due to the loss of husbands and family members as well as the long-term imprisonment of husbands, though they have also gained more rights through new laws and policies. Progressive gender policies in Rwanda include the legalisation of succession for women, new land and property rights for women and men, and the adoption in 2009 of a law on the protection against, and prevention and punishment of, gender-based violence. However, the ongoing transmission of traditional gender norms through institutions such as the family, school and church hamper the effective implementation of the various, mostly top-down, governmental initiatives to prevent gender-based violence. Sociotherapy as a grassroots intervention has proven to be a successful complement to these initiatives and to contribute towards their effectiveness.

Sociotherapy follows a group dynamic approach. The core of this approach lies in the application of a group process to create a “possibility sphere” that facilitates behaviour change. Group dynamics are used to produce a holding environment; an environment that for many people had been lost due to the betrayal, loss of life, separation from family members, and mistrust generated by war and genocide in Rwanda. The experience of safety and trust created by the group dynamics enables people to discuss problems and support each other in a process of change. The implementation of this approach at

grassroots level actively includes the context of people's living environment. This way, the participants' families, neighbours, and other community members are indirectly reached by the intervention. This may result through a process of change from within, as men who do not themselves participate in sociotherapy nevertheless change their perceptions of gender norms and cease their destructive behaviour (see also Slegh & Richters, 2012).

The fact that people's living environment is included in the sociotherapy approach also effectively complements hospital treatment of mental health problems. In a recent meeting organised by the Rwandan Ministry of Health, it was observed that the most difficult problem that mental health services face is that a patient may seem to respond well to the given treatment (usually medicines), once the patient is back home he or she relapses. Sociotherapy may be of help here by facilitating the reintegration of the patient into the community. However, one has to take into account that when a person seeks hospital treatment, it is usually for a specific health problem, while people who join sociotherapy mostly come without a clearly described problem. Going through the sociotherapy process makes them realise that they do have a problem and helps them to solve it.

Informants participating in ongoing sociotherapy research frequently mentioned that, from their perspective, the medicines prescribed for their psychological problems did not always help. Furthermore, regarding individual trauma counselling, they also had their reservations, because a person's living environment is unchanged by the counselling sessions. With sociotherapy, some explained with much conviction, "the group is our counsellor". We have to be cautious here. Sociotherapy so far has mainly targeted people with family problems who have only a few years of education or none at all and are relatively poor. More educated people may find other ways to help solve family conflicts and other conflict-related psychological and social problems. Comparative research on the effectiveness of different kinds of individual and group therapy offered in a country like Rwanda, where social and individual distress in the aftermath of war/genocide are so interlinked and widespread, is recommended here (cf. e.g. Bass et al., 2013).

Despite the positive reception of sociotherapy among the population, sociotherapy faces a number of challenges. We observed in our study, for instance, that although the aim of sociotherapy was explained to group participants at the outset, many were reluctant to openly share private family issues in the group sessions, fearing that they might be punished by their spouses or be considered untrustworthy, because they were not able to keep their family secrets. Some also wondered whether sociotherapy was not just a way of "judging them or reinforcing their dehumanisation". After a few sessions, however, this fear usually disappeared.

Another challenge is that sociotherapy can, instead of promoting women's rights, have the unintended effect of endangering women's lives. Group participants are usually motivated by sociotherapists to be humble and to accept one another's guidance in terms of how to change their spouses' behaviour. This approach does have positive results, but not always. For instance, Ancilla, who refused to have sex with her husband because of his extramarital sexual affairs, was advised by the group to nevertheless have sex with him for the sake of reconciliation. However, accepting this advice would put her at risk of contracting a sexually transmitted infection, since her husband refused to use a condom. In some groups, sociotherapists did not help the group to evaluate the dangers that might occur when accepting all of the group's advice for the sake of reaching reconciliation.

Our study also found that women as well as men can be violent, though we neglected to explore this issue in depth. As Kruger, Straaten, Taylor, Lourens and Dukas (2014) have demonstrated in South Africa, women can be a destructive element in family life due to dire living circumstances. In our case, living circumstances as a determinant of violence by women are most probably intersected by some of the war/genocide-related factors that contribute to partner violence, which we listed in the study findings above. The study by Sleggh and Kimonyo (2010) found that traumatisation of men as a result of war/genocide is an important factor contributing to family violence and community instability. Based on what women told us about their war/genocide experiences more generally, we hypothesise that the same causal relationship applies to women. Some men in our study raised the question of why the current laws and Rwandan culture do not protect men from violent women. Two men, however, did testify that the law does also protect men; they had apparently overcome the culturally engrained shame of admitting as a man that a woman had been violent towards them. These and other gender issues should, if possible, be part of the training of sociotherapists.

Our respondents, both sociotherapists and sociotherapy participants, suggested that if both husband and wife participated in sociotherapy, whether each in the same group or in different groups – as was the case with Aline and her husband (see above) – then reconciliation would become easier. Sociotherapists added the wish to be trained in individual counselling, so that they could apply this when required. For instance, some participants do not share their most significant problems in the group, though they may beneficially do so afterwards in an individual session with the group sociotherapist. There is, however, a limit to what can be expected from sociotherapists who receive only a few weeks' training. Partner violence and mental health problems, for instance, can be so severe that a different kind of expertise is required; expertise that is not sufficiently available. On the other hand, we need to realise that evidence-based research in a number of low- and middle-income countries has shown that in the field of mental health care lay people with a limited amount

of training and supervision “often perform as well as highly trained academics” and that, in general, “therapists’ success is primarily related to the quality of their alliance with patients” (De Jong, 2013, p. 5).

## CONCLUSION

Community-based sociotherapy, implemented as a multi-systemic intervention in a specific post-conflict setting, has proven to effectively contribute to the reduction of partner violence in its areas of operation. It therefore holds promise for other post-conflict settings, where people need to come to terms with a range of family problems as a legacy of past political violence. In Rwanda, the recognition by various stakeholders of sociotherapy’s positive impact on individual and social healing, in addition to peace building from below, has facilitated the start of a new nationwide sociotherapy programme (see Community Based Sociotherapy, n.d.). The very first phase of this programme has already confirmed that a wide range of family issues are at the core of the problems people struggle with. The Byumba programme has taught us that with limited support people can be empowered to break cycles of family conflict and violence and restore social connections damaged by a history of political violence.

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