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Mental Health and Sexual Violence
July 30, 2015 — By Karen Stewart, Licensed Clinical Social Worker

Very early one morning a few years ago, nine-year-old Annie appeared in the waiting area at our clinic in Lae, Papua New Guinea (PNG), clutching her mother and staring at the floor. Her mother told the registrar that Annie had not spoken a word, nor attended school, in two years. She didn't know what was wrong with Annie and wanted her tested to find out if the child had had sex.

I'd arrived in PNG fascinated by the beauty of the country and its culture. It took some time to realize just how pervasive and how dire the problem of violence is there. Having worked with Doctors Without Borders, Medecins Sans Frontieres (MSF) as a mental health officer at other projects, I'd grown accustomed to treating people for a host of issues--living with HIV/AIDS or post-traumatic stress due to conflict, for instance. In PNG, though, we treated survivors of family and sexual violence almost exclusively—more than 4,300 of them in 2012.

Rape and gang rape in PNG have reached the point where many women live in constant fear. Women I met expected to be raped and often prepared for this to happen. I had more than one female staff member approach me and quietly ask for female condoms for their own protection because they were going to be traveling the road to the highlands and women are often raped on this route. I also spoke with a 15-year-old girl who had successfully fought off a rapist. She told me, "I always cinch up my pants very tightly with this belt, it makes it harder for them when they come to rape me."
MSF has since handed over its project in Lae to the health authorities and continues to run a similar project in the town of Tari. The goal of these projects is to create the capacity within the PNG health system to provide the much needed care for victims of sexual and family violence. But there are major challenges.

The Psychological Impact of Sexual Violence
I took Annie and her mother to a private room. Donna, our national staff counselor, joined us, and encouraged the mother to tell us when Annie's behavior had changed. She said her child had become more and more isolated and withdrawn over the past two years, ever since her uncle, the mother's brother, started living with the family.

As the mother continued to talk, it became clear that she had brought Annie to the clinic because she suspected that her brother had been raping Annie for two years and she seemed ready to face the truth and gather evidence. As worried as she was about her daughter, she was also worried that her husband would kill her brother if he found out. This was entirely possible, and maybe even likely, in PNG. It put even more pressure on Annie, the victim.

I cannot overstate the difficulty a survivor of family or sexual violence faces in coming forward. The social consequences and psychological impact can be overwhelming. Many patients have told me about being chased out of their homes, being rejected by their husbands and families, being ostracized and blamed and pulled from school, or having to leave school due to depression and fear.

When we explain to women who have been raped by someone other than their husband now must wear a condom for six months to protect them from the risk of HIV, the women often say they do not want to tell the husband about the rape, and will not be able to ask him to wear a condom without potentially disasterous consequences.
In PNG, and also in my previous work in Zimbabwe, I have seen cases settled out of court when a perpetrator agreed to marry the girl he raped to avoid bringing public attention and shame to her and her family. In extreme circumstances, the victim of rape may be killed by a male family member in an attempt to restore the honor of the family.
The experience of rape and all the potential aftermath can lead to symptoms of chronic post-traumatic stress disorder in victims. These can manifest in physical, cognitive, emotional, and behavioral ways and they include a long list of effects, from stomach issues to problems with sleeping and concentration; from panic attacks to criminal behavior; from social withdrawal to excessive drug and alcohol use.

Knowing that early psychosocial care can prevent or minimize many of these outcomes, MSF added mental health care to its comprehensive sexual violence care. But mental health is very often overlooked by public health care services in resource-poor settings. If sexual violence is addressed at all, it is usually only in the medical and legal capacities.

These are essential, of course, but without addressing the psychosocial impact, the care is incomplete.

The Challenges of Providing Treatment

In my experience, many of the same challenges to treating patients with HIV and TB also apply to treating survivors of sexual violence. We see the stigma, the misunderstandings and the myths, the secrecy, the fear, and, sometimes the refusal of the authorities to recognize the existence and the scope of the problem.

We know that outreach is necessary in order to lower the stigma around talking about sexual violence, and increase people's access to care. We've used simple, easy to read pamphlets and posters in many different countries. Radio is an excellent way to reach women, especially in refugee camps.

In PNG, we directed sensitization campaigns at men to encourage them to respect and protect women and to correct misconceptions about rape—that is isn't a serious crime, for instance; or that it's the women's fault for dressing a certain way or going somewhere she shouldn't have been. We've managed to get a well-known rugby player to deliver some of these messages, which gave them extra weight.

We have also learned that it is best to integrate care for rape survivors into the wider range of community services, including reproductive health, rather than running the risk or even the perception of the risk that they might be singled out. Case in point: at one project in Democratic Republic of Congo, the counselors and patients told me our clinic was known as "the rape clinic" and many women said they would never go there, since

people would know they'd been raped.

It's different in every country, but in PNG many patients did not know they could get medical treatment for sexual violence, and many did not know such a thing as mental health counseling even existed. They came to the clinic specifically to get medical-legal certificates, which MSF provides so victims and their families have a record of the medical observations of the treatment provider that they can use it to seek legal assistance or compensation, or to apply for refugee status.

Misperceptions about mental health counseling can also be challenging. Often people have an image of mental illness as someone tied to a tree or locked in an underground cage, but they have no concept at all of mental health or mental health care. In my experience, the more people know, the more open they are to counseling.

The amount of counseling one might need varies from person to person depending on factors such as the degree of psychological trauma suffered and the person's own coping skills. Some victims experience immediate psychological distress, while others develop long- or short-term psychological problems.

The amount of time we are able to spend with each victim is another big challenge. Even in a more stable context like PNG, some people never returned for counseling after the first session, probably for the same reasons some did not return for follow-up medical care or others do not complete their ARV treatment for HIV: fear of stigma, fear of reprisals, shame and humiliation, denial, not fully understanding the importance of medical and psychological treatment, or simply having problems getting transportation.

Gains and Losses

At MSF projects we focus on the patient's hopes, supports, and strengths in order to build them up in their own minds so they can face the world again. Our aim is to decrease the symptoms and consequences of the trauma they have suffered and increase the patient's ability to cope and function.

The main message Donna tried to get across to Annie's mother was that this behavior in her daughter was a very logical response to the ongoing rape and incest she had been enduring. In other words, it was a normal reaction to an abnormal and traumatic event. Her mother, who had earlier said she would beat Annie in order to get her to listen or do as she was told, needed to offer her child love and support instead, Donna said.

The mother appeared relieved to hear this and even smiled. She seemed enthusiastic to provide her love and affection.

Annie remained silent during her medical exam. When she and her mother came back for a second session the next day, the mother said she needed the medical report to take to the police; she said that she had held off the family from killing the uncle, her brother, by promising to bring the matter to the authorities.

Annie attended a total of five mental health sessions with us. She began to make eye contact with Donna. Once, she even smiled. She did not speak, but she did return to school, and even participated in the grand opening of our new clinic by helping make leis with the counselors and other patients. Her mother reported that her brother had been run out of town and he would be killed if ever returned. She was so grateful and appreciative, she named her new baby Karen, after me.

After the fifth session, Annie stopped coming to the clinic. Donna and I were highly disappointed and very sad. I held on to the hope that we had helped in some small way by reconnecting her with her mother, by ending the rapes and her mother's beatings, by her returning to school. Yet we were left with the reality that without further intervention, she will likely never move through or beyond the trauma.

One of the most difficult parts of this job is dealing with the not knowing. So many patients are "lost to follow-up" and there is no resolution to their cases that we know of. But despite the considerable challenges and limitations, I know mental health care makes a significant difference to survivors. I am often amazed at the resilience of the patients as they continue to move forward.

I often think of something a staff member at the project, a PNG national, said: "As a nursing officer (at a government clinic) I saw women who were raped, beaten, with fractures and I was never able to help them with psychosocial care because the focus was on medical care. Here we provide both. I don't think counseling makes a difference: I know it does. I see it making a difference in the lives of women. We are helping women to find space to move with their emotions and recognize their own value."