

The Impact of Sexual Violence in the Democratic Republic of the Congo: Implications for the Care of Congolese Refugees

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Abstract

The Democratic Republic of the Congo (DRC) remains a hotbed of instability, violence, and human rights violations, driving the displacement and migration of millions of its citizens. The conflict in the DRC is characterized by widespread sexual violence. This paper assesses the profound physical and psychosocial consequences that persist through the process of migration and resettlement for victims of sexual violence from the DRC. A review of the limited survey data available indicates that providers should utilize a trauma-informed approach to best assist in the process of recovery for Congolese refugees who have experienced sexual violence. The effects of sexual violence, particularly psychosocial distress, are often compounded by pre-migration exposure to additional conflict-related traumas, and by the accumulation of post-migration stressors. By identifying and evaluating these stressors, healthcare providers can more effectively evaluate and manage the unique medical and psychosocial needs of this patient population.

Introduction

Plagued by political upheaval and armed conflict for over two decades, the Democratic Republic of the Congo (DRC) has been called “the rape capital of the world” and “the worst place on Earth to be a woman.”^{1,2} Conflict-related sexual violence (CRSV) in the DRC has become a defining feature of the conflict and has drawn international attention on rape as “the war within the war.”^{2,3,4} The characterization of sexual violence (SV) as a “weapon of war” refers to the systematic use of brutality to terrorize, dominate, humiliate, and control civilian populations during wartime.^{5,6,7,8}

The majority of sexual violence in the DRC is directly conflict-related, as perpetrators of mass rape are mostly military or armed combatants from various groups, including militia forces, rebel groups and resistance fighters, and national military (FARDC) forces.^{9,10,11} Sexual violence at the hands of armed groups is often accompanied by additional traumatic experiences, such as murder of family or community members, theft, and destruction of property and resources. Despite

peace agreements and intervention from the international community, outbreaks of violence and atrocities have continued, particularly in the eastern provinces of North and South Kivu. Ongoing instability and the pervasive sense of impunity have contributed to an increase of sexual violence perpetrated by civilians.^{1,8,11} The economic destruction and lack of infrastructure further perpetuate instability and drive looting and opportunistic sexual violence.⁴

Given the pervasive nature of sexual violence in the DRC, medical providers treating refugees from the region should be mindful that many of their patients will have been exposed to sexual violence, either directly or indirectly. While it is difficult to quantify the actual prevalence of conflict-related sexual violence in the DRC, population-based studies have estimated that approximately 40% of women and 24% of men have been exposed to sexual violence.^{6,11,12} However, the rate of non-reporting of sexual violence at the time of seeking medical care has been reported at 75%, largely due to fears of stigmatization.¹¹

Sexual violence has profound physical, psychological, and social consequences that include, but are not limited to, PTSD, anxiety,

depression, sexual dysfunction, poor reproductive outcomes, social isolation and stigmatization, the breakdown of community and family relationships, and economic hardship.^{6,10} Providing care for these patients requires an understanding of the effects of trauma, which are often compounded in the refugee population by the challenges of displacement, migration, and resettlement.

This paper seeks to provide an overview of the physical and psychological impact of conflict-related sexual violence in the DRC, and to provide suggestions to primary care providers for how to provide trauma-informed care for their Congolese patients with a history of sexual violence. Of note, while the primary focus will be on female survivors, a brief discussion of the impact of sexual violence on male survivors is included.

Physical Effects of Sexual Violence

Conflict-associated sexual violence in the DRC often includes extreme forms of violence, such as gang rape, genital mutilation, torture, and the intentional transmission of sexually transmitted diseases.^{2,4,13,14} There are reports of penetration with foreign objects such as guns, knives, and sticks, as well as female genital mutilation, all of which can have devastating effects on reproductive health.¹⁴

Sexual violence, particularly in such extreme forms, may have both immediate and chronic physical effects for survivors (see Box

1). In their studies comparing differential health outcomes among women who experienced conflict-related sexual violence (CRSV), non-conflict-related sexual violence (NCRSV), or no sexual violence, Dossa *et al.* found that the type of sexual violence experienced has profound effects on health outcomes.^{15,16} Unsurprisingly, women who experienced CRSV and NCRSV both experienced worse health outcomes than women who had not experienced either kind of violence. Women who experienced CRSV in particular were significantly more likely to have fistulas (including obstetric or traumatic etiology), chronic pelvic pain, and absence of desire for sex and children. The authors also suggest that higher levels of PTSD associated with conflict may contribute to chronic pelvic pain in this population.¹⁶

Of note, the prevalence of HIV among adults (age 15-49) in the DRC is 0.8%, with 450,000 adults and children living with HIV as of 2018 and 19,000 reported new infections that year.²³ However, the prevalence among armed combatants has been estimated to be much higher.^{3,4} While studies have shown only limited evidence that conflict – including conflict-associated rape – increases HIV prevalence at a population level, modeling suggests that a survivor’s individual risk may increase by a factor of 2.4 to 27.1.^{24,25,26} This is likely a result of the types of sexual violence associated with conflict (including the infliction of genital injury and assault by multiple perpetrators).

Box 1: Physical Effects of Sexual Violence^{4,5,14,15,16,17,18,19,20,21}

Immediate Physical Impact of Sexual Violence	Long-Term Physical Impact of Sexual Violence
Bleeding, miscarriage or intrauterine fetal demise, placental abruption, uterine rupture, premature labor and delivery, discharge, broken bones (including pelvis), cutaneous and muscular injury, other traumatic injuries to reproductive organs and rectum, transmission of STIs, unintended pregnancy	Pelvic, lumbar, abdominal pain, uterine prolapse, fistulas, infertility, dysmenorrhea, menorrhagia, urinary/fecal incontinence, sexual dysfunction, gastrointestinal irritability (pain, nausea/vomiting, loss of appetite, constipation/diarrhea), tension headache, chronic fatigue, fibromyalgia, disrupted sleep, long-term effects of infection with HIV or STIs

Trauma-Associated Fistulas

Defined as an abnormal connection between the vagina or uterus and the urethra, bladder, rectum, or colon, fistulas are one of the most physically and psychologically destructive injuries resulting from sexual violence.^{20,30}

Physical sequelae of fistulas include urinary and/or fecal incontinence, recurrent UTIs, vulvar dermatitis, vaginal stenosis, pelvic pain, social isolation, rejection, and unemployment.^{15,30} Many women living in poverty do not have access to disposable sanitary products and rely instead on pieces of cloth.⁴ Women with fistulas

face significant stigma due to incontinence and infertility,²⁰ as well as perception among some communities that fistulas represent “punishment for immoral sexual behavior or witchcraft.”³¹ Access to reparative surgery is unfortunately limited.⁴

The prevalence of traumatic gynecologic fistulas caused by rape is overall low, even in conflict zones. Studies of women with fistulas in the DRC found that only about 2.7-4% of treated fistulas are related to sexual violence, while most are due to obstetric or inappropriate care.^{30,31} This is consistent with worldwide trends as most genital fistulas are caused by obstetric complications, particularly obstructed labor in the setting of decreased access to appropriate emergency obstetric care.²⁰ For this reason, fistulas are more common in low-resource or rural settings, with the prevalence as high as 2-5 cases per 1000 deliveries.³⁰ Of the women who developed fistulas, many experienced delays in reaching healthcare facilities during labor, or in receiving

Sexual Violence and Pregnancy

Studies in the DRC have estimated the prevalence of sexual-violence related pregnancies (SVRPs) to be 6-17% among survivors of SV.^{11,35,36} Many women do not have timely access to medical care after sexual violence, including emergency contraception. Moreover, many women with SVRPs report they conceived during prolonged captivity.³⁵ Voluntary abortion is illegal in the DRC with the potential for 5-15 years imprisonment under the 1982 DRC Penal Code^{9,35} Despite having signed and ratified the Maputu Protocol, which allows abortion in cases of rape or incest, abortion remains effectively illegal even in the context of sexual violence.^{15,33,34,35} Nevertheless, nearly half of women may seek to terminate SVRPs, often outside of the formal healthcare sector as access to safe, evidence-based abortion and post-abortion care is limited.³⁵ Very few clinics provide abortion services, and often do not do so openly.^{35,36} The most commonly reported methods to induce abortion included quinine and cimpokolo (*Phytolacca dodecandra* L’Hérit). Among women who did not terminate, reasons for continuing the pregnancy included fear of

appropriate care from the appropriately trained providers.

For those women who did have traumatic fistulas, those directly attributable to sexual violence (often due to the use of foreign objects inserted into victims’ vaginas) are less common than “indirectly related” fistulas. This category includes iatrogenic fistulas caused by inappropriate instrumentation to manage rape-induced spontaneous abortion or stillbirth, as well as prolonged/obstructed labor in women forced to live in sexual slavery with the armed groups and who therefore went without appropriate care. Sadly, many women who were pregnant at the time of their assaults experienced intrauterine fetal death. Many of these deaths are likely attributable to placental abruption, though studies have also shown that women who sustain assaults during pregnancy are at higher risk of uterine rupture.³² It seems likely that many more women have died of unknown obstetric complications after assault than population studies are capable of reporting.

death or legal ramifications, lack of access to resources, and religious beliefs.³⁶ The fear of dying from unsafe abortion was even more pronounced among women whose husbands had been killed during the conflict or abandoned them after SV, as many had other children for whom they were the sole caregiver.³⁶ It is difficult to fully estimate the rates of unsafe abortion and its contribution to maternal morbidity and mortality in the DRC. However, studies have estimated that between 8-13% of maternal deaths globally, and at least 12% of maternal deaths in central Africa, are attributable to unsafe induced abortion.^{37,38}

Women with SVRPs are at even greater risk of poor psychosocial outcomes, with higher reported rates of depression, PTSD, anxiety, and suicidality. Notably, this increased risk includes women who terminate SVRPs.^{33,34,35} Women who reported experiencing social stigmatization themselves, or stigmatization of their child, were significantly more likely to meet symptom criteria for MDD, PTSD, anxiety, and suicidality,³⁴ with PTSD the most common.³⁵ Women who reported not having a spouse, or being abandoned by their spouse, were also more likely to meet symptom criteria.

Psychiatric Effects of Sexual Violence

It is well established that “women affected by humanitarian crises have significant trauma-related mental health concerns.”³⁹ The widespread mental health impact from violence, both witnessed and experienced, is certainly not limited to sexual violence. Mental health disorders among refugees from war zones who have experienced sexual violence are likely multi-factorial given the numerous types of trauma experienced.⁶ Sexual violence is often associated with other types of trauma, including the injury or death of family, friends, and community members as well as loss of wealth, property, and livelihood.⁴ Rape victims frequently report experience with imprisonment or forced enlistment in the armed groups during the conflict.⁸ Repeated exposure to trauma of all kinds may have a cumulative, dose-response effect, contributing to increased rates of PTSD and increased severity of symptoms. The accumulation of daily stressors – including unemployment, disease, poverty, poor housing, and social stressors such as stigmatization – is also associated with increased PTSD symptoms.⁸ The increased prevalence of mental health conditions among refugees persists through the process of migration and resettlement. Indeed, refugees experience depression and PTSD at more than double the rate of the United States population⁴⁰ as the stresses of migration, resettlement, and cultural adaptation have profound effects on mental health.⁴¹ Depression itself may compound isolation, whether pre- or post-migration.

Refugees who have also experienced sexual violence experience additional challenges to their mental health. Studies of civilians in the DRC have found higher prevalence of PTSD, depression, suicidal ideation, and suicidal attempts among men and women alike who

experienced sexual violence.¹¹ The most common health outcomes related to sexual violence include post-traumatic stress disorder, anxiety, and depression.^{18,39} Survivors may also have decreased cognitive and executive functioning, behavioral changes, and neurovegetative symptoms (e.g., fatigue and insomnia) above and beyond those associated with major depressive disorder.^{5,33,34} Moreover, the extreme brutality associated with CRSV may explain the increased severity of PTSD symptoms. Women who reported 2 or more perpetrators were more likely to meet symptom criteria for PTSD and suicidality as compared to those who reported 1 perpetrator.³³ Lasting physical effects of sexual violence serve as a reminder of the assault, and may extend the mental health effects of such violence.¹⁶

Shame and Stigma

One of the most profound modulators of mental health for survivors of sexual violence is stigmatization and rejection by family and community.^{2,6,8,18} Social rejection after rape may be as traumatic as the attack itself, if not more so, for some women.^{2,10} Survivors often describe feelings of isolation, abandonment, shame, and guilt. They commonly describe feeling mocked or “pointed at” by the community and often suffer from strained marital and other relationships.⁴² Stigmatization also carries an economic burden for some women who are excluded from school and employment.¹⁸ Women who report higher “felt stigma” have the highest levels of depression, anxiety, and PTSD.⁴² Rejection also increases severity of PTSD symptomatology.¹⁶

A series of interviews with sexual violence survivors and their male relatives identified factors associated with greater likelihood of rejection and abandonment (See Box 2).

Box 2: Factors Associated with Stigma and Rejection^{4,7,10,18,20}

1. Fear of disease (STIs, HIV): Social norms in the DRC fuel the perception of sexual violence victims as “unclean, spoiled, or unfaithful” or “contaminated by disease.” Many believe that women who have been raped are infected with STIs, with the greatest fear surrounding HIV to the point that a husband may not trust a negative HIV test result provided by his wife after rape. Husbands who did not leave their wives may be labeled as “walking dead men.” Respondents also reported feeling that rebel forces tried to spread HIV to destroy the community.

2. Local customs/perception of marriage: Many husbands of survivors felt that marriage was “voided” by sexual relations outside of the marriage regardless of force/lack of voluntary participation. Sexual violence is seen as disrupting the “core tenets” of marriage, including violation of fidelity, which is seen as “a man having the sole right to sexual contact with his

wife.” As one survivor stated, “The woman who has known another man has no more value.” The likelihood of spousal rejection increased if the victim conceived a child after rape.

3. Perception of collusion/relationship with the perpetrators: Not only is a victim’s marriage often considered annulled by rape, but some communities considered her “married” to the perpetrator and feared that the rebels may return to claim their “family,” particularly if a child resulted from the assault (“the Hutus will come back to claim their son”).

4. Social stigma towards male relatives of victims: The assault of a man’s wife or female relatives may be seen as a challenge to his masculinity and role as a protector and provider. Men often report feeling humiliated and seen as “weak” and “useless” by the community, which may cause them to react by withdrawing from the victim.

5. Physical injuries sustained in the injury that may challenge a victim’s ability to fulfill traditional female roles of raising children and performing household chores.

6. Pregnancy resulting from the attack.

7. Assault by multiple perpetrators.

The Male Experience with CRSV in the DRC

Men are directly affected by sexual violence in the DRC, not only through their proximity to female victims, but also through their own experiences with assault. In 2016, the UN Security Council officially recognized men and boys as victims of conflict-related sexual violence.² Contrary to popular narratives, both men and women experience and perpetrate sexual violence.¹¹ While male experiences of SV are largely underreported due to stigma, Johnson *et al* found that of 998 households in the Eastern DRC, 23.6% of men reported having experienced sexual violence (as compared to 39.7% of women in the same sample).¹¹ Another survey of 447 male refugees in Uganda (99% Congolese) found that 38.5% had experienced sexual violence.⁴³ Physical damage from SV may include rectal tears and bleeding as well as damage to the genitals. Reproductive damage may be permanent based on the severity of the physical brutality endured, causing additional stress from infertility.⁴⁴ Male survivors of SV may be at increased risk of alcohol and substance abuse as compared to female survivors, and they are similarly at risk of depression, PTSD, anxiety, and suicidality.^{11,21}

Nevertheless, male victims rarely seek medical attention or share their stories due to fears of shame and stigma. Experiences of sexual violence violate the traditional sense of masculinity regardless of whether the assault was directly experienced (i.e., oneself) or witnessed (i.e. being forced to watch the rape of one’s wife, children, or other family members). Men who are seen as failing to protect their wives and families from assault may have their masculinity challenged, but not to the degree suffered by men who reported being raped,

including some who “instantly became castaways in their villages, lonely, ridiculed figures, derisively referred to as bush wives.”⁴⁵ Men who were directly assaulted risk being labeled as homosexual, which is culturally taboo in the Congo.² Even after fleeing to refugee camps, men face fears over disclosing their assaults – in Uganda, homosexuality is illegal, with a penalty that may include life imprisonment.^{2,46} Moreover, the international response to sexual violence in the DRC has largely focused on violence against women, and with so few researchers, international organizations, or NGOs dedicated to sexual violence against men, male victims are often overlooked regarding policies, resources, and interventions that may be beneficial.

Access to Care in the DRC

Many of the studies of medical care after sexual violence in the DRC are based out of Panzi Hospital in Bukavu, South Kivu Province, a “One-Stop Center” model for holistic care that provides specialized treatment for rape survivors and other women with gynecological injuries.^{19,61} Owned and managed by the Communauté des Eglises de Pentecôte en Afrique Centrale (CEPAC), a Pentecostal church organization, the hospital has provided care for over 50,000 survivors of sexual violence since its founding in 1999. Its co-founder and medical director, Dr. Denis Mukwege Mukengere, accepted the Nobel Peace Prize in 2018.⁶²

While the Panzi Hospital is an excellent example of comprehensive care, with built-in legal and psychosocial support for patients, it is unfortunately far from the norm. As is the case in many conflict and post-conflict zones, the

DRC has suffered the destruction of many of its healthcare centers and resources, leading to shortages of available care, particularly in rural areas. When these centers remain open, they often lack supplies or the ability to handle more complicated cases.⁶ Human Rights Watch reported that fewer than 50% of rape victims have access to basic medical facilities.²⁷ One 2011 study of hospital facilities and resources available to treat victims of sexual violence in Goma, the capital city of North Kivu province, found that only one hospital (of 23 acute care hospitals in the area) had “all resources always available to appropriately care for victims of sexual violence.”²⁸ These shortages include both supplies and appropriate providers: of the four hospitals that regularly treated victims of sexual violence, only two hospitals had anesthesiologists or gynecologists, and only one hospital had psychiatrists/psychologists available. The authors reported these findings to be in line with that of a United Nations report on unmet needs of sexual violence survivors.²⁸

The lack of nearby hospitals, particularly in rural areas, poses a significant challenge to efforts to provide post-assault care in accordance with the standard of care – specifically, to provide HIV post-exposure prophylaxis and prophylactic treatment for STIs within 72 hours of exposure.^{7,13} Although some forms of emergency contraception are effective for up to 120 hours after intercourse, not all forms are available, so most studies of immediate care used the same 72-hour window (the time frame in which levonorgestrel-based contraception is effective) as a marker for timely contraceptive care. Two Medecins Sans Frontiers (MSF)-supported health centers reported that only 60% of patients in Masisi and 32% in Niangara arrived within the 72 hour window.⁹ Some women who eventually sought treatment for sexual violence-related ailments or conditions presented several weeks or months, even years, after the initial assault.⁷ Reasons for these delays in presentation include emotional distress, lack of knowledge of available treatment, lack of financial resources, transportation difficulties, and concern about stigma or rejection. Women with the longest delays often presented because of worsening physical symptoms, or in some cases, had been

unable to seek care after abduction and periods of sexual slavery.^{7,29}

Health Services for Female CRSV Survivors in Refugee Camps

Multiple barriers to care exist for displaced women living in refugee camps after fleeing violence, sexual and otherwise, in the DRC. Access to health facilities and supplies are limited, and the stressful conditions of camp life, including insecurity and poor access to food or healthcare, contribute to worse mental health outcomes.^{16,47} In their study of mental and reproductive health service use among Congolese women residing in short and long-term refugee camps in Rwanda, Bell *et al* found certain health needs received priority over others.³⁹ Specifically, while 90% of the women surveyed received antenatal care, and 81% of all women received an HIV test (including 96% of pregnant women), only 13% of sexually active women were using some form of family planning, and only 7% of women with at least one symptom of an STI sought treatment. This dearth of family planning resources is certainly not limited to Rwandan camps: according to one survey of women in Ugandan refugee camps, 58% reported an unmet need for family planning resources.³⁹ Particularly relevant for survivors of SV, mental health services for women in Rwandan camps were provided by “one social worker with limited training in mental health care, and split between two camps, with a total of 35,000 refugees who had fled civil war and genocide.”³⁹

Supporting Recovery in Primary Care: Treatment Strategies/Implications for Practice

Traumatic pre-migration experiences and their impact on health, particularly mental health, are linked to refugees’ experiences with post-migration settlement and integration.⁴⁸ Recovery is already a difficult, complicated process without the added challenges of migration, resettlement, and adapting to a new country. As the first and often most consistent point of contact with the healthcare system, the primary care provider has an opportunity to play a

significant role in the process of recovery. However, limited evidence exists on which interventions are most helpful in the primary care setting to assist patients in recovery from sexual violence. Given the nature of the resettlement experience, the vast majority of refugee patients establish care in the U.S. months or years after the incident(s) occurred. Regardless of the timeframe, the patient may never have disclosed the assault previously or obtained medical care related to the acts endured.

Practitioners should adopt principles of trauma-informed care in providing treatment and

support to these patients. Trauma-informed care is comprised of “services and interventions [that] keep at the forefront the survivor’s needs, perspectives and choices. It acknowledges the impact of...SV-related trauma on all aspects of a woman’s life, and aims to promote safety and empowerment in her journey towards recovery.”^{21,49} Put more simply, the provision of trauma-informed care requires an understanding of the impact of sexual violence on a patient’s life. There are 10 principles of trauma-informed care (see Box 3).

Box 3: 10 Principles of Trauma Informed Services.⁵⁰

Trauma Informed services:

1. Recognize the impact of violence and victimization on development and coping strategies;
2. Identify recovery from trauma as a primary goal;
3. Employ an empowerment model;
4. Strive to maximize a woman’s choices and control over her recovery;
5. Are based in a relational collaboration;
6. Create an atmosphere that is respectful of survivors’ need for safety, respect, and acceptance;
7. Emphasize women’s strengths, highlighting adaptations over symptoms and resilience over pathology;
8. Aim to minimize the possibilities of re-traumatization;
9. Strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background; and
10. Solicit consumer input and involve consumers in designing and evaluating services.

In their recent article in *Obstetrics & Gynecology*, Ades *et al* describe the Engage, Motivate, Protect, Organize, self-Worth, Educate, Respect (EMPOWER) Clinic for Survivors of Sex Trafficking and Sexual Violence located at Gouverneur Health in New York, New York as a model for providing integrated gynecologic and psychiatric care for survivors of sexual and gender-based violence. This includes “managing the significant long-term medical consequences and sequelae of sexual violence in a trauma-informed setting.” Practitioners who treat refugees from the DRC

may find their recommendations helpful, particularly with regard to conducting the physical and gynecologic examinations in this patient population. Of note, the authors provide a figure that summarizes the recommendations discussed below, as well as additional considerations for providers when interacting with survivors of SV. Please use the following link to view this information through the University of Virginia’s institutional access: <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=image&IMAGE=00006250-201904000-00029%7cFF1&D=ovft>.

Box 4: Goals of the EMPOWER Clinic’s Trauma-Informed Practice²²

- Provide the opportunity to address and discuss trauma directly.
- Consider patients’ medical and surgical histories in the context of their previous trauma(s).
- Evaluate current symptoms and medical conditions in the context of their previous trauma(s).
- Provide routine gynecologic care and health maintenance services using a trauma-sensitive approach.
- Evaluate the need for and provide mental health services.

Many patients may be hesitant to disclose trauma, or may reference it without desiring to share specifics, particularly during an

initial visit with a new provider. For patients who do disclose a history of SV, Ades *et al* recommend asking the following four trauma-

specific questions: 1) when the trauma occurred; 2) the timing and duration of trauma; 3) the identity of the perpetrator in relation to the survivor; and 4) whether the patient is currently safe from the perpetrator or in contact with the perpetrator. While question 4 may seem less relevant to survivors of conflict-related sexual violence in the DRC, it is important that providers not focus too narrowly on CRSV in this population and forget that patients may have experienced multiple forms of trauma and violence, including SV in other contexts. When asking about sexual violence, providers should consider how framing the question in terms of language choices (“forced sex,” “rape,” “non-consensual sexual experience”) may evoke varying responses from different patients.⁸ While obtaining a trauma history is important, providers must be careful to avoid retraumatizing the patient, particularly through asking excessive or unnecessarily probing questions that are not directly relevant to providing care.^{22,51} The authors recommend that at the end of the trauma history, the provider summarizes the forms of trauma experienced and specifically identifies these experiences as traumatic. This may be particularly beneficial for patients who have not sought prior care or who are disclosing their trauma for the first time out of fear of shame and stigma.

Approach to the Physical Examination

Women who have experienced SV often avoid routine gynecologic examinations and preventative care, as the experience of the pelvic examination may evoke traumatic memories of the assault.⁵² Women with a history of SV, particularly women with coexisting PTSD, are more likely to experience pain and distress during the pelvic exam.⁵² The trauma-informed care approach emphasizes that patients have control over their medical care and should be actively engaged in decision-making, including the choice to undergo or defer a gynecologic examination after disclosing SV. If an exam is performed, it is critical to minimize the emotional and physical discomfort as much as possible, both to avoid retraumatizing the patient and to increase the likelihood she will accept routine gynecologic care in the future.

Examiners should be aware that just the exposure of genitalia in the context of an examination may be retraumatizing for survivors, even before any physical contact is made.²² Best practices for physical examination already include limiting the exposure of the patient’s body whenever possible and providing explanations to the patient about what is being examined and the purpose for doing so. These principles are even more critical when examining a patient with a history of SV.²² The examiner should allow extra time to complete the exam, as anxious patients may require additional explanations and reassurance or may need to take breaks during the examination to prevent becoming overwhelmed. If a patient has difficulty bringing her legs apart, the provider should slowly and gently encourage the patient to let her legs fall apart and demonstrate where the knees should be positioned, but should not use touch or pressure to guide the legs.²² While it is normal for women to involuntarily contract the perineal muscles with speculum insertion, survivors of sexual violence may have a hyperreactive response, making the speculum exam more challenging.⁵³ Examiners should be patient while coaching the patient through voluntary relaxation of the perineal muscles, but if this cannot be achieved, the rest of the examination should be deferred. Some patients with difficulty relaxing may tolerate a bimanual examination prior to the speculum exam, which can be utilized to demonstrate to the patient which muscles need to be relaxed. Some survivors may experience dissociation during a pelvic exam as a defense mechanism against perceived danger.^{22,54} If this occurs, the provider should immediately stop and wait for the patient to return to full consciousness.²²

Psychological Interventions and Adjustment to the U.S.

For many patients with a history of SV, it may be beneficial to establish rapport and build trust over time before delving into the impact of trauma on mental health. As with any patient with a history of SV, refugees may react very differently to discussions of their trauma: naming and discussing the experience as sexual violence can be helpful to some, but

traumatizing to others. The unique experience of migration and resettlement may either exacerbate or ameliorate symptoms of psychological distress. For some, the experience of leaving one's country and settling in the U.S. may be perceived as a chance to start over and distance oneself mentally and physically from the attack.⁵ Refugee women may desire to "renegotiate" their identity as victims of the civil war and sexual violence that has plagued the DRC, particularly as the heavy international attention to SV may lead people to assume their status as a survivor regardless of actual experience with SV. This construction of a new narrative can be seen as an "act of resistance to being labelled or identified for what *happened to them* rather than *who they are*."⁵⁵ However, for others, the loss of pre-migration familial and social support networks may worsen mental health outcomes and lead to increased feelings of isolation. Many refugee women with a history of SV express that the discrimination and stigma associated with SV persists among their communities even post-migration, carrying the risk of community and spousal rejection regardless of when the assault is disclosed.⁵⁵ For this reason, patients may be extremely hesitant to disclose their trauma due to the desire to form social connections within a new community and to feel a sense of belonging while preserving one's privacy and dignity.^{5,55}

Given that daily stressors have been shown to have a large effect on mental health, it may be preferable to use a "sequenced approach to interventions" in which daily stressors are addressed first, followed by more specialized psychiatric interventions.^{33,56} This is in line with the expressed preferences of many refugee survivors of CRSV. When asked which support interventions would be beneficial in the process of recovery, refugee women often prioritize more practical and urgent needs over "the need to immediately address and redress personal violations."⁵⁵ Many refugee women also identify assistance with parenting, facilitation of educational goals, and help building community and social supports as more relevant targets for assistance from providers.⁵⁵ Patients may perceive these needs, particularly with regard to providing for their children, as more important

than dealing with the psychological difficulties stemming from experienced trauma.

However, many patients will have significant symptoms of PTSD, depression, and/or anxiety that may interfere with their psychosocial functioning and present further challenges to the post-resettlement adjustment process. It may be helpful, when possible, to refer these patients to mental health clinicians who have specialized training in sexual violence recovery. Multiple treatment modalities have been studied in female survivors of SV. Studies of cognitive behavioral therapy (CBT) and Trauma-focused CBT (TF-CBT) have demonstrated significant improvement in depression/anxiety among survivors of sexual violence.^{57,58} Prolonged exposure therapy (PE) and eye movement desensitization and reprocessing (EMDR) therapy have also been shown to produce lasting improvements in PTSD symptoms.^{51,59} Other treatment modalities such as assertion training, clinician-assisted emotional disclosure, cognitive processing therapy, stress inoculation therapy, and supportive psychotherapy have also been shown to be helpful in reducing PTSD symptoms and symptom severity.⁶⁰ However, there are only limited studies on comparative effectiveness of these treatment modalities, and one intervention has yet to be established as significantly superior. Given this, providers should take an individualized approach to recommending psychiatric interventions that takes into account patient preferences, while emphasizing the potential for significant improvement in mental health symptoms regardless of the treatment modality chosen.

Conclusion

The ongoing conflict in the DRC has become nearly synonymous with sexual violence in the eyes of the international community. However, providers treating refugee patients from the DRC should not simply make assumptions about their experience with sexual violence. Rather, it is recommended that providers carefully screen all patients from the DRC for a history of trauma, including sexual violence, while being mindful that patients may be hesitant to reveal such history given pervasive fears of

stigmatization and rejection. Refugees with a history of sexual violence face additional challenges to their physical and psychological health that may be compounded by the accumulation of prior non-sexual traumas, as well as current stressors inherent to the resettlement process. Many refugees prefer a stepwise approach to care in which concrete,

immediate needs of the patient and her family are addressed prior to delving into a history of sexual trauma. Providers should adopt a trauma-informed approach to eliciting a history, performing an exam, and engaging in shared decision-making about treatment options with patients.

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