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'They came with two guns': the consequences of sexual violence for the mental health of women in armed conflicts

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Abstract

Sexual violence has serious and multiple consequences for the mental health of women. At the psychological level, it leads to radical changes in the image that the victim has of herself, in her relations with her immediate social circle and beyond, in the community as a whole, and in the way in which the victim sees the past, present, and future. It thus has a lasting negative impact on the victim's perception of herself, of events, and of others. At the community level, it stigmatizes the victim, depriving her of any social status or intrinsic value as a person (she is seen as unfaithful or promiscuous), and thereby modifies relationships within the community with an overall deleterious effect. This article discusses these consequences of sexual violence for the mental health of women, especially those who are its victims during armed conflicts.

Psychological and social processes are so closely linked as to be virtually indissociable. Thus conditions that undermine a woman's ability to adapt to her social environment, such as stigmatization or discrimination, can jeopardize her mental

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health.[1] Conversely, any psychological disorder, such as mental trauma or psychosis, can prevent a woman from playing an active and constructive role in her community. Both mental health and social integration are key to understanding and meeting the daily challenges of life, to feeling and expressing a range of emotions, and to maintaining positive relations with others. It is therefore important to examine the consequences of sexual violence for both social integration and mental health.[2]

Social consequences

Sexuality touches on a myriad of values and taboos governing the behaviour of both individuals and society at large. At individual level, most people are repelled by the idea of engaging in sex outside a given context (e.g. marriage or a loving relationship) – being subjected to forced sex is a distressing and humiliating experience.

Thanks to their sexual and reproductive abilities, women play a major role in building and preserving the clan-based, ethnic, or cultural identity of any society in which they live. Groups form alliances through marriage, and such alliances are strengthened every time a child is born. It is therefore not surprising that sexual practices are dictated by the social contract[3] and that access to sex is regulated, codified, and organized by all societies – and is sometimes even the subject of legislation. In most traditional cultures, sexual relations are permitted only within the confines of a marriage agreed to by the families concerned. The betrothed are generally expected to be of the same ethnic group, tribe, caste, or religion; an intimate relationship or marriage within any other framework is out of the question.

1 See Evelyne Josse, 'Déceler les violences sexuelles faites aux femmes', 2007, and idem, 'Accueillir et soutenir les victimes de violences sexuelles: approche orientée vers la solution', 2007, both available at http://www.resilience-psy.com/ (last visited 1 March 2010).

2 For interventions by humanitarian organizations see Evelyne Josse and Vincent Dubois, *Interventions humanitaires en santé mentale dans les violences de masse*, De Boeck Université, Brussels, 2009; Inter-Agency Standing Committee (IASC), *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies, IASC Taskforce on Gender in Humanitarian Assistance*, Geneva, 2005, available at http://www.humanitarianinfo.org/iasc/downloadDoc.aspx?docID=4402; International Committee of the Red Cross (ICRC), *Women Facing War*, ICRC, Geneva, 2001, available at http://www.icrc.org/Web/eng/siteeng0.nsf/html/p0798; ICRC, *Women and War*, ICRC, Geneva, 2008, available at http://www.icrc.org/Web/eng/siteeng0.nsf/html/p0944; Réseau des Femmes pour un Développement Associatif, Réseau des Femmes pour la Défense des Droits et la Paix, and International Alert, *Le corps des Femmes Comme Champ de Bataille Durant la Guerre en République Démocratique du Congo. Violences sexuelles contre les femmes et les filles au Sud-Kivu (1996-2003)*, Study, 2004, available at http://www.grandslacs.net/doc/4051.pdf; United Nations High Commissioner for Refugees, *Sexual and Gender-based Violence against Refugees, Returnees and Internally Displaced Persons*, UNHCR, Geneva, 2003; World Health Organization (WHO), *Mental Health of Refugees*, WHO, Geneva, 1996; 'Sexual violence', in E. G. Krug, et al. (eds.), *World Report on Violence and Health*, WHO, Geneva, 2002, available at http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf (all last visited 19 April 2010).

3 The social contract is an agreement among individuals whereby organized society, with its hierarchical structure, is established. It consists of rules and laws that ensure social order.

Sexual violence breaks every social convention relating to sexuality. It generally exposes the victims to stigmatization, often to discrimination, and it may jeopardize their position in society. In many societies, victims of sexual violence are blamed for their fate. Traditional beliefs and prejudices are used to justify their state of disgrace in the eyes of the community. Rape and other forms of sexual coercion are equated with adultery. The victims are considered to be under an evil spell cast by their own inappropriate behaviour (for instance, towards a family member) or to be suffering divine punishment for alleged sins, including so-called provocative dress or behaviour that supposedly drove the perpetrator to commit the violent act.

Victims of sexual violence are also discriminated against, in that they may be shunned, stripped of their rights (whether legal or traditional), and deprived of access to goods and services. They are frequently prevented from speaking out, rejected by their spouses, prevented from marrying, forbidden to take part in certain activities (such as preparing and serving food, growing and harvesting crops, or nursing children), and excluded from school and work. Wherever they go and whatever they do, victims of sexual violence are made to feel ashamed and are ostracized, whether by their families and communities, schools, employers, places of worship, legal institutions, or medical facilities. In some cases, whether in war or peace, they are 'buried alive' by society.

Impact on marriage

Rejection by husband and strain on marital relations

Sexual violence can result in a variety of difficulties between husband and wife: it often has a dire effect on sexual relations (loss of desire or disgust on the part of the victim and/or her husband, pain during intercourse, etc.) and on emotional bonds (trauma-induced suffering can lead to personality disorders that affect interpersonal relations, bringing about arguments or conflicts).

In traditional societies, a husband will frequently reject (through repudiation or divorce) or abandon his wife after she has been raped, or he may leave home for increasingly long periods of time. In cases where the husband stays, he often neglects his wife (especially by refusing to have sex with her), acts distant, or mistreats her. In some cultures, a raped spouse is banished from the conjugal bed or forbidden to prepare meals for her husband. In countries where polygamy is practised, the husband of a rape victim will often take a second wife. The risk of being repudiated or divorced is greater if the victim is pregnant as a result of rape.

The reasons that drive a husband to reject his wife after she has been raped are multiple: he may be afraid of contracting a sexually transmitted disease (STD) – especially HIV/AIDS – or he may balk at the consequences of an unwanted pregnancy; feeling stigmatized or fearing that he may be so treated in future, the man would rather leave his wife than risk becoming the object of ridicule; or he may feel dishonoured by an act that, in his culture, is assimilated with adultery.

Impact on family relations

Rejection by and strife within the family

Sexual violence can tear a family apart. A young unmarried woman who has been raped may be barred by her family from returning home. If she is allowed to come home, she may be deliberately ignored by her parents or subjected to humiliation and taunts (insults may escalate into arguments or outright conflicts).

Girls who have been forced to have sex with rebel fighters may be viewed as having defected to the enemy, and may therefore be stigmatized as 'opponents', opening the way to rejection by family members or by the community at large.

Impaired parenting skills

Rape victims may no longer be able to look after or meet the needs of their children, whether for physical reasons (long convalescence from the injuries sustained, disability caused by the rape, etc.), psychological reasons (trauma, clinical depression, psychotic delirium)[4] or cultural reasons (in some societies, rape victims are not allowed to nurse or prepare food for their children). Even when they are allowed to fulfil their duties as parents, they often become irritable or aggressive towards their children.

Parental authority is often undermined by rape. Children who have been forced to witness their mother's rape or to have sexual relations with her often show lack of respect for her or despise her. They refuse to obey her and blame her for not having resisted her attacker.

Children of rape

Children born as results of rape are often abandoned, rejected, or ill-treated (not as well fed, educated, or cared for as other children), and are sometimes murdered. This may occur even when the rape victim, her husband, and their families have agreed to keep the child.

Impact at community level

Rejected by the community

Rape victims often speak of the shame that they experience. They talk of being mocked, ridiculed, denigrated, insulted, humiliated, and disparaged. When they go out in public, they risk being made fun of by villagers who parody songs in a

4 Persons suffering from psychotic delirium lose their sense of reality, sometimes experiencing hallucinations, and are unaware of their condition.

demeaning way, using the victim's name, interrupt their conversation, or change subjects when the victim walks by, and whisper, giggle, or exchange knowing looks in her presence. Villagers may also point at the victim or stare at her with obvious disdain. A rape victim may also find that her behaviour, however ordinary, is seen as morally reprehensible and is unfairly associated with the rape. Thus, if she disagrees with a friend or a family member, she may be told 'You're just acting stupidly [i.e. refusing to see things my way] because you were raped'. Often, the victim is prevented from expressing her opinion (for example, she may be cut off mid-sentence and told 'Not you!'). In addition, old friends may stop talking to her or refuse even to see her.

Exclusion from schools and jobs

Girls who have been raped are often seen as bad examples and therefore expelled from school, especially if they are pregnant. Likewise, those who have jobs are often dismissed.

Unfit for marriage

In traditional cultures, single women who have been raped no longer have any chance of being married and those who were promised find their engagements broken off. In many societies, a family's honour depends on the virginity and chastity of their daughters. Sexual violence is viewed as a source of shame, and the victims are dishonoured and perceived as unfit for marriage. Yet, in such societies, marriage is often the only way for a woman to achieve social or economic status of any kind.

Trauma of forced marriage

In some societies, a girl or single woman who has been raped is forced to marry the perpetrators in order to restore her family's honour.

Violence

Women or girls who have experienced sexual violence run the risk of being ill-treated or even murdered by their families ('honour killings' carried out to restore the family's honour, which is seen as having been trampled on by sexual violence). In some societies, rape victims are punished by their communities or by law[5]

5 This is the case in countries under sharia law (Islamic law). In some of these countries, a charge of rape can only be upheld if the perpetrator admits his crime or if the rape has been confirmed by four adult male eyewitnesses (or, in some cases, by eight female eyewitnesses). Failing this, the rape is equated with adultery and accusations made by the victim against the perpetrator are deemed slander.

(they may be convicted of a crime and sentenced to prison, flogged,[6] stoned to death,[7] etc.) for having had illicit sexual relations.[8]

Relatives of the victim may attack (or kill) the perpetrator or members of his community in order to take revenge or defend the family's honour.

Repeated assault

In some societies, victims of sexual violence are at higher risk of repeated assault because other members of their community, who now despise and disparage them, are no longer willing to protect them.

Impact at individual level

Isolation

Despised and rejected, victims of sexual violence often withdraw from society of their own accord in order to avoid feeling threatened or humiliated. They may cease to go places (such as churches or choir practice) where they are likely to run into old friends who turn away from them, or they may move far away from their villages. In some cultures, isolation is forced upon the victims by their families or spouses who keep them locked up at home, hidden from prying eyes, to save the family from public disgrace.

Inability to function in society

Fearing repeated violence or feeling physically or psychologically vulnerable, rape victims often cease their professional activities and stop performing their daily chores (for example, they no longer dare go to work in the fields, fetch wood, draw water, and so forth). Girls often drop out of school, either temporarily or for good; this reaction is sometimes dictated by the social norms of their communities. In some societies, victims of sexual violence are expected to drop many of their activities, including preparing and serving meals, growing and harvesting crops, and nursing their children.

6 In December 2007, King Abdullah of Saudi Arabia pardoned Touria Tiouli, a victim of gang rape. This 39-year-old woman, a French national of Moroccan origin who was working in Dubai, had been sentenced to six months in prison and 200 lashes for 'adultery'.

7 The case of Aisha Ibrahim Duhulow, a 13-year-old girl who was raped by three men, was particularly dramatic. The al-Shabab militia, one of the armed groups that controls Somalia, convicted her of adultery in violation of sharia. As a result, she was stoned to death on 27 October 2008.

8 In the Qur'an, for instance, illicit sexual relations are defined as a criminal offence (*hudud*). They include sexual relations (whether consensual or not) engaged in by an unmarried person (man or woman) and those engaged in by a married person (man or woman) outside of marriage. Since rape involves sexual relations outside of marriage, it is often considered as a criminal offence and punished accordingly. This interpretation of rape is not exclusive to Islam. In sub-Saharan Africa, rape is also frequently associated with adultery, owing to the widespread belief that a man cannot force a woman to engage in sex against her will.

Indirect social consequences

Victims of sexual violence may descend into increasing poverty as a result of unemployment[9] or high medical bills.

Stigmatization of family members

In addition to the consequences suffered by the victim herself, sexual violence has a direct impact on the wellbeing of her family. Feelings of humiliation and shame extend to her relatives, who may also be mocked, singled out, or even prevented from expressing an opinion. Socially stigmatized, the victim and her family encounter difficulties within the community at large.

Psychological consequences

Sexual violence can seriously affect the victim's mental health, with dire consequences in the short, medium, or long term. In the hours and days following the event, the victim may present a wide range of physical, emotional, cognitive and behavioural symptoms. Although they may be unsettling or appear strange, most of these symptoms are considered to be normal or at least expected responses to an extreme and terrifying event. They may nonetheless be difficult for the victim and her family or friends to cope with.

In the month following the event, the stress level will remain high but should gradually decrease. As the victim begins to adjust to what has happened, her symptoms should ease and eventually disappear altogether. In some cases, owing to the nature of the event (intensity, severity, duration) or to individual variations in vulnerability (highly emotional personality, mental disorder, prior trauma) or environment (lack of family and social support, presence of stigmatization or discrimination, etc.), the symptoms may persist and become chronic.

Three months after the event, the persistence of symptoms, their growing intensity, or the appearance of new symptoms all point to deep-seated suffering and lasting psychological trauma. A number of these symptoms, it should be said, are not specific to sexual or other forms of violence but may appear in other circumstances as well. Those that are specific to post-traumatic stress disorder (PTSD) are: the impression of reliving the event, dissociation, avoidance symptoms,[10] and neurovegetative symptoms.[11]

After experiencing sexual violence, some women act rationally, whereas others display behaviour that is inadequate or inappropriate (e.g. stuporous inhibition, uncontrolled agitation, individual panic flight, incessant and incoherent

9 See 'Exclusion from schools and jobs' above.
10 I.e. avoiding thoughts, feelings, or conversations about the traumatic event.
11 I.e. symptoms leading to dissociation from society, including physical, emotional, and cognitive symptoms.

talking, etc.) and predisposed individuals may show psychopathological behaviour (e.g. brief reactive psychosis). These initial responses do not predetermine the outcome. Within days or weeks of the event, some victims whose initial responses were inappropriate see their symptoms lessen and disappear spontaneously, while others whose responses were adequate begin to display psychotraumatic symptoms (for instance, impressions of reliving the event) and develop PTSD, which may be short-lived or become chronic. Only time can tell which victims will adjust and which will experience long-lasting trauma. Those who show peritraumatic signs of dissociation[12] are more likely to develop long-term psychological problems. However, many end up overcoming the psychological trauma spontaneously.

Emotional responses

Among the most common emotional responses displayed by victims of sexual violence are: fear, anxiety, anguish, depression, shame, guilt, anger, euphoria, and apathy. From a psychological point of view, fear, anxiety, and anguish are all distinct emotions. They are nevertheless closely interrelated and all three point to the stimulation of the ortho-sympathetic nervous system.[13]

Fear

Fear is a feeling of dread relating to an existing or impending situation that is perceived as dangerous. After experiencing sexual violence, the majority of victims suffer fears that they did not have before. Among the most common are fear of repeated assault, fear of situations reminiscent of the assault, and fear of the social and medical consequences of the assault.

Fear of repeated assault may include fear of being raped, kidnapped, beaten, or tortured again. Victims often fear that the traumatic event that they experienced may recur. This feeling can be heightened by any situation that is reminiscent of the assault (such as an unexpected noise in the bushes, the news that others in the community have been assaulted, etc.). Such fears are characteristic of PTSD. In war zones, of course, they may be entirely justified. Thus, it is not uncommon for armed groups to raid villages and capture sexual slaves whom they had previously freed or for them to rape the same women during repeated incursions into a village.

Fear of situations reminiscent of the assault is characteristic of post-traumatic syndromes. Depending on the circumstances of the assault, victims may fear, among other things, going to work in the fields, being alone or in an isolated area, being in the dark, night-time, strangers, armed men or men in uniform, and sexual intercourse. Even when these situations do not present any obvious

12 I.e. dissociation during or immediately after a traumatic event.
13 The purpose of the ortho-sympathetic nervous system is to raise the alarm and prepare the body for action.

danger,[14] victims may experience intense and uncontrollable fear when faced with them, hence the avoidance behaviour.[15] However, such fears may also be perfectly justified. In some places, the risk of rape, assault, or kidnapping by bandits or militia roaming the fields in search of food is very real.

Fear of social consequences includes fear that others will find out about the assault, fear of their reactions, fear of being rejected by one's spouse or being denied the opportunity to marry, fear of being ostracized by the community, and fear of being thrown out of school. As we have seen, these fears are entirely justified in traditional societies where victims of sexual violence are often made to feel ashamed and unwanted by their spouses, families, and communities.

Fear of medical consequences may include fear of having contracted a sexually transmitted disease (especially HIV/AIDS), of being pregnant as a result of rape, or of having suffered irreversible physical harm (incontinence,[16] sterility,[17] or disability[18]). These fears as well are fully justified by the existence of a genuine risk.

Anxiety

Anxiety may be defined as a feeling of insecurity or of being threatened. In contrast to fear, it can occur in the absence of any obvious danger or specific source of apprehension (context, place, person). A majority of victims of sexual violence become anxious, though most of these women were not beforehand. In severe cases, anxiety can take the form of a diffuse state characterized by permanent underlying apprehension. Victims are constantly worried and experience excessive and recurrent fears relating, for instance, to their health or that of their families, or to their future or that of their children. They generally have feelings of impending doom. They often have a morbid awareness of their problem (they know that their apprehension is exaggerated or unfounded) but they nonetheless find it difficult if not impossible to overcome. The overall state of anxiety is accompanied by symptoms such as agitation, fatigue, inability to concentrate, irritability, muscular tension, and sleep disorders. The persistence of these symptoms over time leads to personality changes, with the person becoming fearful, hopeless, and dependent.

14 Such fears are sometimes mistakenly called phobias. In relation to psychotraumatic syndromes, it is more accurate to refer to 'pseudo phobias' as they are the result of conditioning that has arisen from a real situation. This is not the case with 'true' phobias.

15 Avoidance behaviour is an instinctive response. It may be defined as a defence mechanism designed to increase the chances of survival in a dangerous situation.

16 Vesicovaginal or rectovaginal traumatic fistula (perforation of the membrane between the vagina and the urinary or the digestive tract), a potential physical consequence of sexual violence, causes leakage of urine and stools.

17 Resulting from trauma or from a poorly treated infection.

18 Resulting from sexual violence or from torture or beatings (deafness, blindness, partial or total paralysis, amputation, etc.).

Anguish

Anguish manifests itself as acute episodes known as panic attacks or anxiety attacks. These attacks occur when the victim is exposed to anything that reminds her of the traumatic event (whether flashbacks or new situations), but also – without any particular reason – in situations that present no threat at all. They usually last from a few seconds to a few minutes. These attacks, which are characterized by a paroxysmal feeling of imminent danger, are accompanied by profound distress and unpleasant physical symptoms[19] such as palpitations (the sensation of an irregular heartbeat), tachycardia (acceleration of the heartbeat), a feeling of suffocation (shortness of breath, the sensation of weight pressing down on the chest), chest pains, perspiration, chills, and hot flashes.[20]

Anxiety and anguish are exacerbated by any difficulties that the victim may face, such as material losses owing to looting, financial difficulties following expulsion from her home or rejection by her husband, social ostracism and discrimination, or poor living conditions in camps for refugees or displaced persons.

Symptoms of depression

Although most victims do not develop clinical depression,[21] almost all feel, at some point, sad and hopeless. Symptoms of depression include sadness, loss of interest in life, suicidal impulses, feelings of powerlessness (e.g. feeling unable – especially as a woman – to defend oneself, improve one's lot in life, etc.), discouragement, pessimism, hopelessness, and the feeling that the future holds nothing good. These symptoms may be accompanied by crying spells, constant weeping, feelings of dejection, suicidal thoughts, suicide attempts, or suicide itself.

Feelings of shame

Most victims of sexual violence feel humiliated and disgraced. They are ashamed to be with other people and regard themselves with disgust and hatred. They feel soiled or sullied, have lost all self-esteem (sometimes wondering if they are still human beings), and feel that they have lost their intrinsic value (for instance, as a woman or a wife).

Feelings of guilt

Victims of sexual violence may feel guilty about their own behaviour (self-reproach): for instance, for not having defended themselves, for having preferred rape to death, for having failed to flee when warned of an impending incursion, or

19 These physiological changes distinguish anguish from anxiety.
20 These symptoms point to the neurovegetative stimulation of the ortho-sympathetic nervous system.
21 According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), a diagnosis of clinical depression depends on a number of specific symptoms being present for at least two weeks.

for having gone to the place where they were assaulted. These feelings of guilt are for the most part linked to preconceived notions and/or an exaggerated sense of their own responsibility. 'I should have known what was going to happen', they tell themselves, even if the event was, objectively speaking, totally unforeseeable. They may also have feelings of guilt towards others – for instance, for having brought dishonour on their husbands, children, or families.

Anger

Victims may feel anger against the perpetrators, against all men, against an armed group, against war, or against their husbands and communities for having rejected them.

Euphoria

In the first few days following the assault, victims may experience euphoria stemming from their relief at having escaped death.

Apathy

Apathy is the absence or suppression of emotions or desire, leading to indifference. Apathetic people are indifferent to the outside world, have lost their motivation, and have no interest in their usual occupations (daily tasks, work, school, and leisure). As a result, they do less and less.

To conclude, there are significant differences between people in the way that they express their feelings and cope with suffering. Some externalize their emotions in obvious ways – by weeping, screaming, becoming agitated, and so forth – while others repress or hide their emotions and remain calm on the surface. The way in which people express their suffering does not necessarily reflect their underlying feelings. The absence of outward signs of emotional distress does not mean that a person is not suffering, will not develop disorders later on, or does not need help.

Somatic reactions

Psychological suffering may lead to physiological symptoms or trigger a physical illness.

Physiological symptoms

Somatoform disorders are characterized by physical complaints that suggest a somatic origin but cannot be demonstrably linked to any organic pathology. In other words, the patient is suffering from physical symptoms in the absence of any diseased organs. Even though these disorders take a somatic form, they qualify as mental disorders because they are caused by psychological factors.

Physical asthenia: This can be defined as chronic fatigue that is unrelieved by rest, the rapid onset of exhaustion following the slightest physical effort, and a persistent feeling of weakness and/or of general weariness. Most victims of psychological trauma experience this syndrome.

Pain: Victims often suffer from abdominal, chest, or muscular pain (back and neck pain), headaches, and generalized pain.

Neurovegetative symptoms: The neurovegetative system[22] controls the internal organs (brain, heart, intestines, lungs, etc.) and maintains basic vital functions (breathing, blood circulation, digestion, and the excretion of urine and faecal matter). Its stimulation, characteristic of PTSD, can trigger any number of symptoms, including dizziness, lipothymia (brief fainting spells), trembling, sweating, hot flashes, heart palpitations, tachycardia, pain and oppression in the chest (sometimes mimicking angina), gastro-intestinal disorders (nausea, vomiting, diarrhoea, or constipation), a sensation of constriction in the larynx ('lump in the throat'), difficulty breathing and a pseudo-asthmatic sensation of suffocation, and pins and needles in the extremities (e.g. at the fingertips or around the mouth).

Sexual dysfunctions: These are frequent among victims of sexual violence and include decrease or loss of sexual desire, aversion to sex (disgust and avoidance of sex), anorgasmy (failure to experience orgasm), dyspareunia (painful coitus), vaginismus (involuntary spasm of the vaginal musculature severe enough to inhibit or prevent intercourse). In rare cases, there is an increase in sexual desire and activity, especially among women who have been used by armed groups as sexual slaves.[23]

Menstrual disorders: Amenorrhoea (absence of periods), menorrhoea (profuse periods), dysmenorrhoea (painful periods), and irregular periods can stem from psychological trauma, in this case caused by sexual violence.

Conversion disorders: Rare but very striking, these disorders cause symptoms and deficits in voluntary motor function and in sensory and sensorial functions. They include motor disorders (e.g. gait disturbance, paralysis of an arm), loss of sensation (e.g. in a limb), blindness, deafness, aphonia (loss of speech), and other symptoms devoid of organic causes suggesting a neurological or other physical disorder.

Such somatic complaints may well stem from an emotional disorder, but prudence is in order: while they may reflect sadness, anguish, or trauma, they may

22 The neurovegetative system, also known as the autonomic nervous system, comprises the orthosympathetic and para-sympathetic systems.

23 Cases have been reported in the Democratic Republic of the Congo, in the provinces of Ituri and North and South Kivu.

also point to the presence of an organic illness or be the consequence of physical violence.

Somatic illnesses

Stress and traumatic suffering may also lead to or aggravate an identifiable somatic illness affecting, for instance, the following systems:

- cardio-vascular: hypertension, angor (angina), and myocardial infarction (coronary thrombosis);
- respiratory: asthma;
- digestive: gastroduodenal ulcer, irritable bowel syndrome (spastic colon), and colics;
- skin: eczema, psoriasis, and alopecia;
- endocrinal: diabetes and hyperthyroidism.

Cognitive symptoms

The most common cognitive[24] symptoms displayed by victims of sexual violence are: repetition syndrome, memory disorders, dissociative symptoms, confusion, and impaired concentration.

Repetition syndrome and impression of reliving the event

These are indicative expressions of PTSD, characterized by the fact that the victim replays the traumatic event (rape, kidnapping, torture) in her head over and over again or believes that she is actually reliving it. They include flashbacks, repetitive memories, nightmares, and fear of the event recurring, along with the psychological distress it caused and the physiological effects it had.

Flashbacks: These are memories of all or part of the traumatic event that suddenly intrude on the victim's thoughts and seem real. Flashbacks are usually visual (the victim may have the impression of 'seeing' the rapist) but they can also involve other senses, such as hearing, smell, or touch (for instance, the victim may have the impression that she can hear the rapist's breath, smell his odour, or feel him breathing down her neck). These memories seem absolutely real for a brief moment, at most a few seconds. Thus, for a split second, a woman may 'see' her rapist instead of her husband during sexual relations, or a girl working in the fields may briefly think that a branch blowing in the wind is her rapist emerging from the bushes.

24 Cognitive science is the study of mental processes, i.e. knowledge, learning, thought reasoning, consciousness, imagination, memory, language, etc.

Repetitive and intrusive memories: These memories spring to the victim's mind involuntarily. The victim does not wish to recollect the traumatic event but cannot help thinking about it all the time. Such memories differ from flashbacks in that the victim is aware that they are occurring in her mind and does not confuse them with reality.

Mental ruminations: The victim repeatedly asks herself questions about the traumatic event, dwelling on it and wondering about its significance and consequences (such as her husband having abandoned her, the material difficulties that rejection has brought about, etc.). These incessant ruminations reflect the victim's worries and anguish.

Nightmares about the traumatic event: The victim has nightmares in which she relives the sexual violence and from which she usually awakes with a start. She may dream, for instance, that soldiers are chasing her and she may wake up just as they are about to grab her.

Fear that the traumatic event will recur: The victim may have the impression that the event is about to happen again, especially if anything occurs to remind her of it (e.g. an unexpected noise, hearing the story of another rape victim).

Distress and physiological symptoms: Victims of sexual violence experience distress (fear, anguish, feelings of helplessness, sudden fatigue, etc.) and display physical symptoms (palpitations, tachycardia, sweating, etc.) when they are exposed to anything that reminds them of the event.

Memory disorders

These are central to post-traumatic symptomatology. Victims may suffer from any of the following disorders: traumatic amnesia (partial or total), traumatic hypermnesia,[25] difficulty memorizing new information or repetitive and intrusive memories of the event.

Dissociation symptoms

These are among the diagnostic criteria for PTSD. People are considered to suffer from 'dissociation' when they are disconnected from part of reality. They give the impression of 'not being there' or of 'being elsewhere'. They do not appear to hear what is said to them. They are physically present but their bodies are often unresponsive and their minds are elsewhere. Some tell the same story over and over

25 'Traumatic amnesia' is the inability to remember certain aspects of a traumatic event, while 'traumatic hypermnesia' is unusual clarity of memory regarding a particular aspect of a traumatic event, generally a sensorial one.

again, without seeming to notice the person whom they are addressing and with their eyes riveted to the traumatizing scenario that is unfolding within.

Depersonalization: This disorder can be described as an alteration in the perception of the self. Some victims are cut off from their own identities; they feel that they are no longer themselves. They experience splitting (e.g. they see themselves from the outside), feel that they are spectators of their own lives, act mechanically like robots, or feel completely estranged from their bodies.

Derealization: This is a loss of the sensation of the reality of one's surroundings. Victims feel detached from their surroundings, they have a feeling that people and things around them are strange or unreal, that they are living a waking dream or nightmare, that they are strangers in a once familiar world.

Traumatic amnesia: This is the effect of dissociation on memory.

Peritraumatic dissociation is considered to be the clearest predictive sign of chronic PTSD. Dissociative behaviour is in fact an adaptation strategy.[26] However, if it is pervasive (e.g. total amnesia or partial amnesia affecting important areas of experience), it increases the risk of psychotraumatic syndrome because the event in question cannot be integrated by the victim. It should be said, however, that many victims who display dissociative symptoms eventually recover their mental stability spontaneously and that some even say that they are relieved that they cannot remember the horrendous details of the traumatic event.

Confusion

This shows itself as disordered consciousness accompanied by the slowing of thought processes, disturbed orientation (in time or space), and impaired ability to reason, understand, take decisions, and make choices. Some people are plunged into a state of confusion such that they can no longer say their names or respond to simple questions.

Impaired concentration

The main symptoms are distraction and attention deficit disorder.

Behavioural symptoms

Victims often display abnormal behavioural symptoms that can become habitual, causing health problems and affecting their family and social lives. These

26 An adaptation strategy consists of a cognitive change (change in thought pattern) or a behavioural adjustment (action) made by a person in order to cope with an 'imbalance between demands and resources', whether internal or external. See Richard S. Lazarus and Susan Folkman, *Stress, Appraisal, and Coping*, Springer, New York, 1984.

symptoms include: avoidance behaviour, hypervigilance, jumpiness, sleep and eating disorders, dependence, altered hygiene habits, relational problems, unusual attitudes, and strange behaviour.

Avoidance behaviour

This type of behaviour is characteristic of psychotraumatic syndromes. Victims avoid anything that reminds them of the traumatic event. They avoid thoughts (they do not wish to think about the event), feelings (they flee situations that elicit the same feelings as the event), conversations (they refuse to talk about the violence that they endured), activities (they cease or are reticent to engage in activities that they associate with the event, such as cultivating the fields, going to market, etc.), places (they stay away from the place where the traumatic event took place – for instance, a particular field), and people (such as armed men or men in uniform) who remind them of the event.

Hypervigilance

Victims often show symptoms of hypervigilance. They look for signs of danger obsessively, remain in a state of permanent alertness in the hope of avoiding another assault, cannot seem to rest or relax, and so forth.

Jumpiness

Traumatized people jump at the slightest sound (especially sudden or loud sounds) or when they hear noises that remind them of the traumatic event (e.g. footsteps or rustling in the leaves that could signal the presence of an attacker, cracking sounds like that of gunfire, etc.).

Sleep disorders

Victims frequently complain of insomnia, of having trouble falling asleep, of waking up in the middle of the night or very early in the morning, and of nightmares.

Eating disorders

Sexual violence may upset eating patterns. It is not unusual for a victim to experience anorexia or bulimia.

Dependence

Psychological suffering often leads to the abuse of alcohol, psychotropic drugs (tranquillizers, antidepressants, anti-anxiety medication, sleeping pills, pain-killers, etc.), or hard drugs. Recourse to psychoactive substances is an attempt

to self-medicate as a means of overcoming trauma symptoms (nightmares, repetitive memories, flashbacks), related disorders (depression, anxiety), or stress responses (neurovegetative hyperstimulation), or as a means to escape from reality.

Altered hygiene habits

Hygiene habits are frequently upset by sexual assault. Victims may display either an increased preoccupation with cleanliness (e.g. compulsive washing) or, on the contrary, sink into total negligence (refusal to wash).

Interpersonal disorders

These disorders are characterized by an attitude of dependence and an increase in emotional demands placed on family and friends (insatiable need for affection and support, constant need to talk and be listened to, etc.) or, on the contrary, by a turning inwards (refusal to talk to anyone, deliberate isolation, avoidance of contacts with family and friends or colleagues), and by irritability and aggressive behaviour towards others (fits of anger, verbal, or physical abuse), distrust, and suspicion (towards men, strangers, etc., but also towards friends, family, or colleagues) and so forth. These disorders are partly determined by the circumstances surrounding the traumatic event. If the victim was assaulted while she was alone, for instance, she may want to be constantly accompanied; if she was gang raped, she may withdraw and want to be left alone.

Uncharacteristic behaviour

Victims may display behaviour that is uncharacteristic: for instance, they may be irritable, burst into tears at the slightest provocation, show suspicion without cause, be negative or pessimistic, or be hyperactive or agitated. Or they may seem unusually calm or even sluggish, talk incessantly (logorrhea), be aggressive towards themselves (self-mutilation, suicidal thoughts, self-destructive habits such as alcoholism), and so on.

Strange behaviour

This type of behaviour is rare and appears only among persons who are particularly fragile or already have a psychiatric history. It includes running away from home (without an obvious reason or a specific aim), wandering aimlessly, displaying an attitude or expression that is inappropriate to the emotional context (for instance, laughing while telling a tragic story), compulsive rituals aimed at exorcising evil (such as lengthy prayer sessions), loss of contact with reality (brief reactive psychosis, or auditory or visual hallucinations), and so forth. Victims who become delirious subsequent to sexual assault generally present symptoms that are directly related to the traumatic experience. For instance, a woman who has witnessed the

execution of her husband may 'hear' gunshots and 'see' blood everywhere even after she is safe.

Mutually reinforcing consequences of sexual violence

As mentioned at the outset, psychological and social processes are closely interdependent. Thus, the social consequences of sexual violence produce psychological suffering and, conversely, psychological suffering has an impact on the victim's relationship with her family and community. The following are just some examples that illustrate this mutually reinforcing effect.

Social consequences leading to psychological suffering

Being rejected by or deprived of support from one's spouse or family, or being forced to remain single or to marry one's rapist are consequences that inevitably produce deep psychological suffering.

The disgrace and ostracism to which victims are subjected have a major impact on their self-esteem. They tend to blame themselves and internalize the negative perceptions that others have of them. This leads to a loss of confidence and self-respect. They may also have feelings of guilt if they are held responsible for their misfortune. All of this may plunge them into a state of depression and despair from which they are convinced they will never escape.

Psychological impact leading to social consequences

A person suffering the effects of trauma has a reduced ability to act, communicate, and interact, and consequently has diminished social skills. Emotional withdrawal or, in contrast, excessive dependence on family and friends, irritability and aggressive behaviour towards others, and lack of interest in and loss of enthusiasm for ordinary activities all tend to disturb family and community dynamics.

Fear and psychological dysfunction (delirium, apathy, constant feeling of dejection, general loss of interest, panic attacks, difficulty concentrating) interfere with or may even prevent a person from accomplishing ordinary tasks such as working in the fields. This can deprive the victim of her means of subsistence and reduce her to poverty. In many societies, women are responsible for the education of their children. Thus, when psychological problems interfere with parental duties, children grow up deprived of the basic conditions for healthy development. Fear, shame, disgust, and sexual dysfunction (dyspareunia, vaginismus) prevent some women from having normal sexual relations, and their husbands may leave them as a result.

There are many facets to a person's life, with the psychological and social aspects forming only part of the picture. Physical health, for instance, has a direct effect on mental stability and social integration – and vice versa. Thus, the physical trauma caused by sexual violence induces psychological suffering that

heightens the trauma. Conversely, psychological suffering has an impact on physical health.

Psychological effects of physical trauma

Becoming pregnant, sterile, or severely disabled as a result of rape can be the source of major distress. Likewise, symptoms of sexually transmitted diseases (STD) contracted as a result of rape (foul-smelling vaginal discharge, urinary incontinence, sick spells, etc.) induce feelings of embarrassment, shame, and anxiety. Miscarriage brought on by physical violence committed against a pregnant woman leads to painful feelings of loss.

Physical effects of psychological trauma

Abuse of alcohol, which often occurs after a trauma, can have dire health consequences (such as liver disease, stomach ulcers, hypertension, or diabetes) and lead to high-risk behaviour (unprotected sexual relations, disregard for safety rules, provocative attitudes, and other types of dangerous behaviour). Meanwhile, psychological suffering may result in physical symptoms (pain, asthenia, menstrual disorders, etc.) or cause a physical illness (such as an ulcer, asthma, or diabetes).