Chapter

Sexual Abuse and Mental Health in Humanitarian Disasters

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Abstract

This chapter provides an overview of the importance of addressing mental health issues due to sexual violence in humanitarian disasters. It provides an overview of the relevance of sexual violence in conflict and its connection to mental health concerns and a heightening of the impacts of the humanitarian disaster. Sexual violence further destroys societies and increases the repercussions of the humanitarian disaster for decades after the conflict has ended. The very high levels of sexual violence that accompany humanitarian disasters are not inevitable. Underlying cultural and societal beliefs that exist before the humanitarian disaster occurs can be aggravated and brought to surface to further exasperate the negative impacts. Large scale public health initiatives that use marketing such as radio, billboards, social media, and television advertisements for example can be helpful and impactful for changing awareness and consciousness of societal norms and assumed inevitabilities that happen in societies. Humanitarian disaster research has revealed that it is common for individuals to view sexual violence as normal and for perpetrators to minimize the effects of it. However, this is a coping strategy that does not take away from the individual, societal and familial mental health effects of sexual violence from humanitarian disasters.

Keywords: sexual violence, humanitarian disasters, mental health, trauma, stigma

1. Introduction

Sexual violence is an issue that has gained increasing attention in recent years. It was only in 2002 that the World Health Organization officially recognized sexual violence as a key issue that needed attention for global health, development and gender equality concerns [1]. Sexual violence leads to significant mental health concerns and issues including difficulty sleeping, depression, anxiety, panic, Post-Traumatic Stress Disorder, and physical issues resulting from societal, cultural, familial repercussions or physical repercussions directly from the sexual abuse itself. It destroys and breaks down families and societies. It undermines poverty reduction and health efforts, and creates whole generations of children born from rape, especially in regions that have experienced war such as the Democratic Republic of Congo (DRC), or Rwanda for example [2].

In fact, the conflict, accompanying levels of rape in the DRC and resulting trauma, mental illness and societal and familial breakdown as a result of mass rapes have increasingly become a point of investigation on the relationship between humanitarian disaster and sexual violence. Investigation into the DRC alone reveals the interconnection and relationship between humanitarian disaster, conflict,

rape and the resulting breakdown and further societal destruction beyond just the humanitarian disaster. In addition to this, investigation into the situation in the DRC is revealing for understanding the underlying issues that exist and contribute to mass rape as well as the resulting mental health and societal detriments. There is a significant dearth of information on this topic and issue in the current literature, and the significance of identifying sexual violence in relation to mental health and humanitarian disasters is revealing for how little understanding exists on how to prevent and treat the issue, as well as its accompanying negative impact on the consequences of a humanitarian disaster [3].

Through investigating case studies of situations such as in Somalia, the Democratic Republic of Congo, Rwanda, Haiti, and even Hurricane Katrina, we can come to see that there is definitely a direct connection between sexual violence and humanitarian disasters and that furthermore, this connection existed before the disaster even occurred due to underlying cultural, societal and familial belief systems. "Rape is normal here" is a phrase one may hear while spending time in many of these regions that have experienced humanitarian disaster. However, many don't even define sexual violence as rape, but rather as nonconsensual sex. It becomes a way of life, a norm, a part of 'the way things are.' In humanitarian disaster areas regions, it becomes normal not only for militant combatants to commit rape but also for civilians. It is typical for fifteen-year-old girls to be gang raped multiple times, over multiple periods of time, to become pregnant and then kicked out of their families forced to raise the baby on their own with no education, money and to live in shelters with other survivors of rape. It is culturally enforced to not to talk about it, report it, or say anything and if you do, for you or your family to be threatened with violence. It is societally normal for the rare few that do try to report to be treated extremely poorly, blamed and mocked for what happened to them and nothing come of it. Sexual violence connected to humanitarian disasters creates situations for rape survivors to be infected with HIV or other STDS, perpetrators to normalize sexual violence, husbands to reject their wives, and fathers and brothers to reject or harm their family members. The normalization of the issue further exasperates the phenomenon and engrains it more deeply into a culture. Normalization does not improve the situation, it makes it worse [4].

When sexual violence occurs at the level it does in humanitarian disaster situations, it changes society in a deeper way than just the conflict or disaster did. It creates intergenerational harm that tears down the fabric of families and creates a new generation of traumatized survivors. Babies born from this trauma may find themselves abandoned, rejected, with a parent that hates them and growing up around other children who are 'rape babies.' It creates a new norm for an already severely damaged society. Despite the efforts of survivors and perpetrators to behave as if it is normal and life can keep going, it deeply damages societies in ways that last decades beyond the actual disaster that occurred. Therefore, prevention and intervention efforts concerning sexual violence are a necessary part of humanitarian disaster relief efforts. Cultural and gender norms and beliefs about sex, need to be addressed before a conflict even occurs. Societies that breed these issues, had these issues before the disaster occurred. The idea that rape is a natural consequence of war or disaster is one such societal belief that significantly contributes to these circumstances and problems [5].

2. The relationship between humanitarian disasters, sexual violence and mental health

The highest rates of sexual violence related to humanitarian disasters occur with conflict, war-zones, post conflict regions and the resulting internally displaced

population groups that are created as a result of this. Female internally displaced populations, both child and adult, show the highest rates of sexual violence, as well as corresponding gender-based violence. This is true worldwide and is not specific only to a certain culture or region. For example, for women that were displaced due to the natural disaster of Hurricane Katrina, there was a 3-fold increase in intimate partner violence, and a 54-fold increase in the prevalence of sexual violence compared to before the disaster. In addition to this, gender-based violence also creates psychiatric issues such as significantly increased depressive symptoms, posttraumatic stress disorder (PTSD) and suicidality. In a study conducted in war-related experience in Bosnia-Herzogovina, the intensity of depression was strongly correlated with the frequency of physical and sexual abuse. It can be life threatening and dangerous to screen for gender-based violence and sexual violence in war-crime areas. Some individuals that agree to participate in screenings or interviews with aid organizations or others are threatened with further sexual violence, physical abuse or death [6, 7].

In Eastern Congo for example, women or children that come forward to share about any sexual violence they have experienced may not only experience shame and rejection by their families and local society and culture but also death threats and further rape and violence as a result of sharing what has happened. The normalization of sexual violence towards children and women in war-zones is not only damaging and extremely harmful for the women that are violated, but to the children born as a result of rape, and to other women in society that learn to become increasingly fearful due to pervasive gender-based violence. The normalization of perpetrating rape also destroys families, hurts society and creates higher levels of poverty and psychological and physical trauma. This psychological trauma leads to a worsening of the conditions from the humanitarian disaster and makes it even harder to recover. The overall resulting psychological trauma from sexual violence in conflict has significant ramifications for overall recovery in the society at large [8].

Due to the importance of this issue, and the fear of reporting sexual violence where it is either not possible or unsafe, a screening tool that assesses for sexual violence using psychological indicators is a useful way to obtain more accurate data on the prevalence of the issue in a society. By screening for strongly associated psychological symptoms such as suicidality, post-traumatic stress disorder, and depression, it is possible to ascertain data that might otherwise be impossible to obtain [9]. A study of Hurricane Katrina with 194 participants out of a possible 32,841 internally displaced female participants in the Louisiana and Mississippi area found that the odds of post-disaster gender-based violence were 2.5 times more likely with identified sleeping problems, 3.8 times more likely with reported appetite dysregulation, 2.3 times more likely with reported lower self-esteem, and 2.7 times more likely with reported suicidal ideation. In addition to this, each reported depressive symptom increased the odds of post-disaster gender-based violence by 1.2 times. Depressive symptoms, including appetite dysregulation, sleep difficulties, self-esteem and suicidal ideation were most significant in determining the rough estimation of the prevalence of post-disaster gender-based violence [9].

The innovative screening approach applied to the mental health outcomes of Hurricane Katrina survivors, looks at the symptoms that we already know from the literature are most strongly associated with sexual violence in disasters, and uses those symptoms to deduce the probability that gender-based violence occurred. It may not be a perfect mechanism by screening for symptoms of sexual violence, but due to cultural barriers and norms, the trauma of conflict and lack of safe reporting in a humanitarian disaster, this may be a more effective approach to deduce the most accurate data [9].

3. Prevention and intervention

There is generally a gap in psychosocial services provided in a humanitarian disaster, as well as a gap in information on these services. Psychosocial interventions attempt to help survivors cope with the psychological effects of a societal breakdown and social world damaged by violence or disaster. It aims to provide a sense of stability to destabilized situations. Stability is a critical component of addressing the needs of survivors or sexual violence in humanitarian situations. The research base for understanding best practices in psychosocial interventions is limited and varied. A study by Mollica and colleagues, on Cambodian refugees on the Thai-Cambodian border found that the creation of opportunities to improve economic productivity improved psychiatric outcomes. In a study of Bosnia-Herzegovinia and Croatia humanitarian conflict and instability, Agger and Mimica found that group meetings and shared activities reduced psychiatric morbidity compared to individual therapeutic interventions. These two situations alone point to the significance of investigating and understanding the individual experience and perceptions in a culture and implementing culturally and environmentally relevant interventions given the provided conditions. This is especially true with such as culturally sensitive issues such as sexual violence. Forcing a certain type of intervention on a population is not only immoral, it also can be at least ineffective, but on the worse end, harmful. Therefore, due diligence to understand the population you are assisting and to try to view interventions from their perspectives is essential [10–12].

Overall, there is very limited information on effective intervention and prevention programs for mental health issues caused by sexual violence in a humanitarian disaster. However, the information we do have is helpful and relevant for informing new and better ways to address the complexity of sexual violence, and its resulting mental health issues in humanitarian disasters. There is some research that implementing psychological first aid and basic interventions after a humanitarian disaster is effective for relief and providing support for mental health concerns resulting from sexual violence. However, there is conflicting information on the provision of best practices. Other more recent research points to more complex interventions that are evidence-based and targeted specifically at treating mental health issues due to sexual violence [13–16].

Other interventions point to the importance of providing cultural, societal, and familial education in mass regarding gender-based norms, sexual violence and the damage it causes. There needs to be education to help reveal that it is not normal and not acceptable to cause sexual violence in any form and that it is not the fault or responsibility of the victim, it is the fault of the perpetrator. More focus needs to be placed on the perpetrator as well as the harmful reactions by friends, family and society to victims of sexual violence. Survivors are traumatized multiple times. First by the violence they experience and then often by the rejection, judgment and harmful reactions from others. Survivors go from a world where they are relatively safe, to one where their safety has been violated on multiple levels by the perpetrators and the reactions and hurt by others. Those that are supposed to most support them, generally cause additional harm and they may find themselves further ostracized by society and family as a result [13–16].

So how do we address the multiple levels of pain and suffering the survivors experience. One option is to implement an education program to combat social norms and stigma. Stigma is a significant part of addressing this issue and is a core part of the psychological damage that is caused at many levels. A "Training the Trainers" program designed to combat social norms and stigma and to openly address the sexual violence that occurs is a potential intervention that could be effective in making a difference in cultural norm change. Included in a "Train the Trainers" program,

there needs to be educational and cultural reform regarding rape, sexual violence, babies born from rape, as well as a promotion in reporting, education of rights regarding sexual coercion, and an increase in opportunities for women to participate in political, economic and social activities, human rights education, and engagement with men and boys on human rights, including gender equality. Additional factors that may play a positive role in changing cultural norms include microfinance initiatives and savings programs for women [1, 8, 13, 14, 16, 17].

Incorporation of significant cultural factors such as religion and churches as supportive tools for education and support may also be relevant, if the church is supportive. Research has shown that in certain cultures, engaging with religion and spirituality can be a supportive factor of coping for sexual violence victims. However, this is also assuming there has been no prior or current sexual abuse experienced through religious or spiritual leaders. It may also be supportive for coping to have a female spiritual or religious led intervention for children, men and women that have been sexual abused by men. This has been demonstrated as an effective intervention in Columbia for example, where there are the most internally displaced people in the world. The use of churches to provide psychosocial support is an example of a culturally relevant program to create reform [18].

Another potential intervention tool is providing screening for mental illness and sexual violence after a humanitarian disaster. However, due to extreme underreporting of sexual violence in societies both during humanitarian disasters and in general, as well as a lack of understanding and a normalization of sexual violence, it is possible that mental health needs assessments that also screen for sexual violence may not be accurate. It may be better to screen for what are known indicators of mental health concerns related to sexual violence. For example, self-isolation, depression, Post-Traumatic Stress Disorder symptoms, dissociation, drug or alcohol use, intrusive thoughts and memories, etc. However, for survivors of violence and humanitarian disasters it can be difficult to differentiate the experience of trauma related to sexual violence, and mental health issues related to the general trauma that have been experienced. Therefore, a more effective approach may be to screen for mental health concerns along with a general humanitarian relief response and provide the option of giving information on the experience of sexual violence if desired. For example, when providing humanitarian relief for hunger and nutritional concerns, to also integrate a very brief screening for mental health and signifiers of mental health issues related to sexual violence, while giving recipients the opportunity to discuss and report sexual violence related mental health symptoms if they feel safe and ready to do so. This allows for an increase in mental health response and initiatives, as well as demonstrates an increased need for mental health services [6].

However, a general mental health screening provided through general humanitarian relief such as nutritional and sanitation interventions, also provides an opportunity for survivors to discuss needs for issues related to sexual violence. Issues related to sexual violence are often difficult to discuss due to cultural-related shame and religious beliefs. For example, some estimates predict that 90% or more of women from the Congo have experienced some kind of sexual violence due to conflict-related sexual violence. However, very few women will report due to cultural beliefs and cultural discrimination. Therefore, other mechanisms of screening may be more effective in terms of providing services and addressing mental health needs. Mental health needs resulting from sexual violence are not only significant in terms of quality of life and recovery. They are also important for the economic, physical and developmental impacts they may have for transitioning a society from emergency to development. They also have a significance for the intergenerational transmission of trauma and the physical results that are due to this which can

include an intergenerational transmission of low cortisol levels and decreased immune system responses [8].

A positive and effective intervention for the initial early stages of mental health intervention may include psychological first aid. This may include listening (not forcing talk), demonstrating compassion, ensuring basic needs, mobilizing support from family members or significant others, and protecting the survivor from further harm. A mental health action plan for complex emergencies may include first a coordination of any and all mental health care activities. Secondly, an early rapid baseline assessment and monitoring of the population's early resiliency and risk factors, the vulnerable group's mental health disorders and the available mental health resources to address them as well as a monitoring system established to review changes in baseline over time. Next and thirdly psychological first aid should be made available for the entire population, identify and triage seriously mentally ill for psychiatric treatment, and work to initiate community-based resiliency and integration of mental health services to help restore to normal everyday life [19].

Fourthly, mental health services in the local community need to be built up by providing training and education with local doctors, healers, hospitals, clinics and international relief workers. There needs to be an integration of resources that already exist in the community into interventions in order to increase and improve mental health work and apply scientifically validated and established interventions. Efforts need to be made to train all first line humanitarian responders in psychological first aid and basic mental health principles and culturally relevant evidence based mental health interventions. In addition to this, the local community should be engaged in the action plan and implementation of these efforts and an informed consent of mental health processes should be honored and acknowledged. There should also be effective, compassionate care for relief workers that helps them with managing their stress and prevents burnout and other mental health related concerns. This should be provided in a safe, non-punitive confidential setting. Lastly, mental health interventions should be addressed for their cost-effectiveness and overall benefit to individuals and the community [19].

The mobilization of primary care doctors and community providers to apply mental health interventions is an effective intervention and approach. This mobilization can occur both locally or through the use of mobile clinics. These primary care doctors can be very effective addressing issues such as depression and in applying basic cognitive behavioral therapy approaches. Depression is one of the most debilitating mental health concerns worldwide, and is often a consequence of a humanitarian disaster situation or can be worsened by a humanitarian disaster. Depression is also a consequence of sexual violence experienced during a humanitarian disaster and also a symptom of PTSD and trauma. Depression is generally treatable, however left alone without support it can easily worsen and even increase the probability of depression symptoms in children or other dependents in a household [1, 19, 20].

The Global Burden of Disease study in 1990 established for the first time the connection between mental illness and its burden on mortality and disability. It found depression to be the fourth greatest disease burden in 1990, and predicted depression to be the second leading disease burden by 2020. However, some estimates predict, especially with the on-going COVID pandemic that the disease burden of depression now comprises the greatest health burden in the world. Therefore, when there are humanitarian disasters, increased conflict and sexual violence and a decrease in stability and breakdown of infrastructure in a society, depression and trauma related symptoms are likely to increase significantly as a result [19].

4. Potentially most significant trigger for sexual violence and resulting mental illness in a humanitarian disaster

There is a dearth of information on effective interventions for mental health consequences of sexual violence in humanitarian disaster situations. It is widely acknowledged that violence against children and women increases during conflict, natural disasters and humanitarian crises. Humanitarian disasters and conflict increase the vulnerability of already more vulnerable groups to sexual violence. The conflict and humanitarian disasters in Afghanistan and Syria for example, have greatly increased the number of female child marriages and the risk of violence and abuse that female children experience. Other regions such as South Sudan and Somalia for example see rises in rape and group rape as a result of conflict, drought, hunger and other humanitarian crises. However, the crises and conflict aren't necessarily the root causes of the sexual violence and coordinating trauma and mental illness. The underlying issues of social and gender norms, the way that love is learned, and the power dynamics within societies and cultures are all triggered and aggravated when there is severe stress on any system [19].

However, addressing underlying root issues of cultural beliefs and power dynamics, and the way that all individuals in a society are respected and given human dignity even before there is conflict or a humanitarian crisis is not only an important part of prevention but also addressing the psychological consequences from sexual violence. Gender equality is one piece of the issue, however depending on how it is measured, perceived and evaluated, it doesn't necessarily mean sexual violence won't be an issue in the event of conflict or humanitarian disasters. This is in part because of the history and cultural beliefs, as well as family and intergenerational patterns that are passed down from generation to generation. Some of the beliefs, like racism, sexism, xenophobia, homophobia, and other types of prejudices, in times of relative stability, abundance and peace may not be as expressed or societally acceptable. However, there is a trend throughout the world that instability, disasters, disease, poverty, hunger, drought, and other crises can bring out toxic beliefs, patterns, hatreds, power and control issues and prejudices that may not otherwise be accepted and brought to the surface. For example, in Germany the poverty and depression that many Germans experienced in the 1930's led to the reemergence and scapegoating of prejudice and old hatreds of certain groups such as people of Jewish descent. In the United States, we have recently seen how COVID-19 has triggered underlying societal issues of racism that were largely suppressed in cultural consciousness before COVID-19 [21].

Another way of framing this is that when beliefs are tested, their authenticity might not be as deep as expected when not under stress or duress. Meaning, on the surface in a society, it may not be socially acceptable to participate in perpetrating sexual violence, however, if given the opportunity and certain conditions, an individual would not stop themselves and would even perpetrate it multiple times because the conditions allow and promote these underlying belief justifications and motivations. Therefore, this points to a very significant differentiation between 1) the surface beliefs individuals hold when there is less stress in a society due to outside conditions functioning at a higher level (ie. when there is no humanitarian disaster) and the societal tolerance for something like perpetrating sexual violence is lower versus 2) higher stress on a societal system due to a humanitarian disaster and higher tolerance culturally for perpetrating something like sexual violence. This points to the reality, that it given the right conditions, someone would perpetrate sexual violence because the barriers and consequences are low. Their ethical locus of control is external, not internal. The unconscious beliefs that perpetuate sexual

violence can be passed on through cultures and societies, so that an individual is not even conscious of them until they are tested by challenging or changing circumstances. Situations of conflict and humanitarian crisis definitely test underlying cultural constructs and can reveal the ugliness of opportunity that may not otherwise be revealed. Conflict and humanitarian crises demonstrate and test whether an individual will participate in sexual violence when circumstances change and which populations are made even more vulnerable than before [21].

5. Country contexts

When implementing interventions, it is relevant and important to investigate the unique manifestation of sexual violence in various country contexts that have experienced humanitarian disasters. In many cultures with sexual violence and humanitarian disasters, it is not only the perpetration of sexual violence that creates mental illness. It is also largely the response from society and family to the survivors. In some societies, there is victim-blaming, shaming the survivor, forcing them to marry their perpetrator. In some cultures, there are even honor killings where family members kill the survivor of violence for the honor of the family. In Syria for example, many refugees have gone to Jordan. The young female refugees are at high risk of perpetration of false marriage by men from other countries that are hoping for sex with a young virgin female. Syrian teenage girls at the refugee camps in Jordan, are often sold by their families for one-hour marriages, or maybe a marriage that lasts several days. The purpose of this marriage is the buying and selling of sex. Due to the impoverished conditions the families live in, they often consent under duress, essentially prostituting their female children for money. In many other countries such as Somalia and the Democratic Republic of Congo, even if a survivor goes to the police, they may be treated with prejudice and told they are at fault by the police themselves, or even if they have a rape kit done, the rape kit may never be processed for evidence. Throughout the world, the treatment of sexual assault survivors generally creates greater harm for the survivor, if they are a child or an adult and there is little focus on accountability and intervention for the perpetrator [22].

6. Proposed framework for investigation

There has typically been a belief or understanding that addressing mental health issues related to sexual violence in conflict and humanitarian disaster areas is somewhat linear. That it begins with 1) prevention before the event or heightened circumstances occur, then 2) addressing the situation when the events occurs, and then 3) addressing the aftermath of the effects of the event. Another way of understanding and viewing this is to see it cyclically. Meaning an intergenerational pattern that occurs through the conscious and unconscious belief patterns that exist within societies, families, cultures, religions and even between couples and within ourselves [19]. A diagram created by the author is provided below to better demonstrate the cyclical nature of the underlying harmful belief patterns that emerge in reaction to a humanitarian disaster (**Figure 1**).

Therefore, addressing conscious and unconscious societal norms that relate to sexual violence and investigating how those norms manifest themselves is critical for addressing the issues. In addition to this, to best address this cycle of violence and prevent it from flaring up as severely as it potentially could, there need to be long-term grassroots funding and interventions. A typical humanitarian funding intervention may be twelve months is length. It is not typically long-term and is

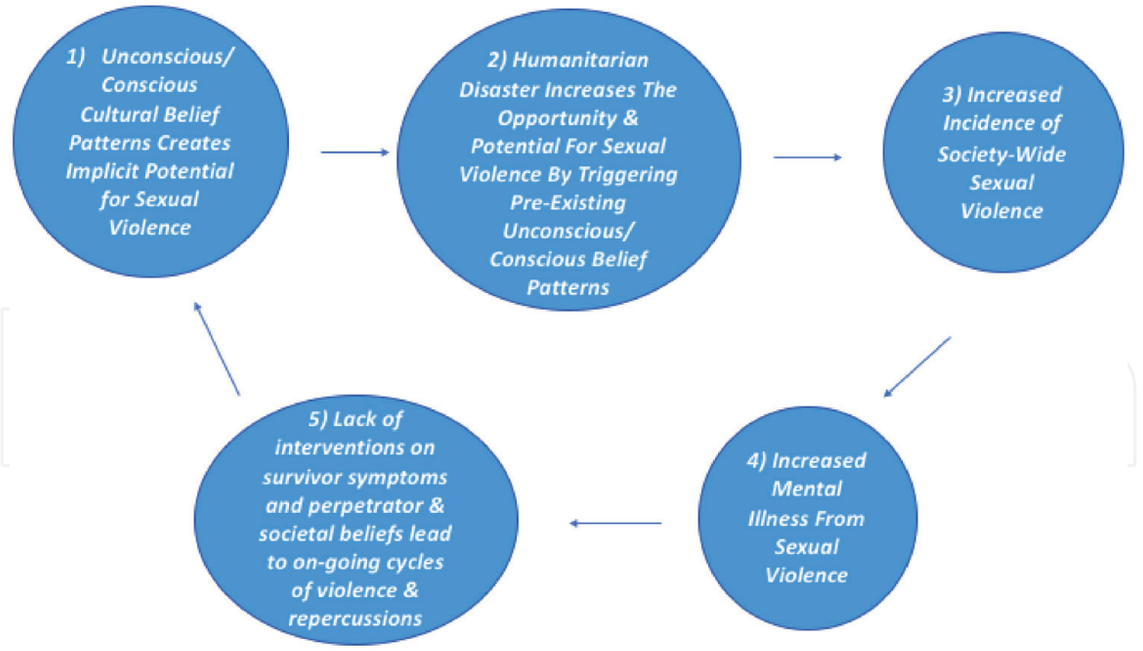

Figure 1.
Framework for understanding societal belief systems that perpetrate sexual violence.

built on addressing emergencies, symptoms and aftermath from conflict and crisis. However, to shift negative cultural beliefs and norms requires longer term interventions that may even be intergenerational. Short-term interventions that address the symptoms of the trauma the survivors experience and the consequences of the perpetrator's actions are incredible, but they are not enough to sufficiently impact the layers and depths of what triggers these issues during conflict and humanitarian disasters [23].

7. Conclusion

An innovative, effective approach to addressing mental health issues due to sexual violence in humanitarian disasters is possible. Through the evidence base that currently exists in the literature, there are certain interventions that may prove more effective than others. A significant component for addressing the problem of mental illness due to sexual violence in humanitarian disasters is for the society and culture to recognize the issue. A normalization of sexual violence does not reduce the mental health impacts that occur such as depression, post-traumatic stress disorder, difficulty sleeping, loss of appetite and other trauma symptoms that generally co-occur. In fact, a normalization of the issue can create social stigma for those that speak out and try to seek help for the problem or stop the problem from occurring. Stigma alone increases mental illness and social damage. The process of de-normalizing sexual violence in humanitarian disaster situations, particularly in conflict regions, is powerful, innovative and will likely result in significant positive change.

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