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Displaced African Female Survivors of Conflict-Related Sexual Violence: Challenges for Mental Health Providers

Adeyinka M. Akinsulure-Smith[1]

Abstract

Conflict throughout Africa has created havoc for many. This overwhelming chaos has led to the disintegration of social order and generated widespread gender-based violence. As a result, African women have become casualties, experienced brutal acts of sexual violence, and been forced into exile. Drawing on the tribulations of displaced African female survivors of conflict-related sexual violence, this article discusses these women's experiences and highlights the barriers and struggles encountered while seeking refuge. The article concludes by exploring the challenges of providing culturally informed, strength-focused mental health services to these women as they rebuild their lives in a new sociocultural context.

The African continent has struggled under the weight of numerous social, political, and economic problems, including poverty, famine, disease, and corrupt government. In the last two decades, the consequences of these burdens have risen dramatically due to the explosion of armed conflicts and religious, ethnic, and political tensions throughout the continent. The human cost of this constant upheaval has been devastating for numerous African countries, including Central African Republic, Côte d'Ivoire, the

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Democratic Republic of Congo, Eritrea, Ethiopia, Kenya, Liberia, northern Uganda, Rwanda, Sierra Leone, and Sudan (Arthur, 2008; Takougang, 2003; Takyi, 2002).

During armed conflict, civilians face multiple stressors, including threats to life, loss of loved ones, financial hardships, scarcity of resources, torture and sexual violence, and the witnessing of violence toward others (Ward, Horwood, McEvoy, Shipman, & Rumble, 2007). Although all members of society suffer greatly during armed conflict, it is the most vulnerable, women and children, who comprise the vast majority of civilian casualties. On many fronts, women and children are more likely to be the innocent victims of warring factions and the recipients of male violence and aggression (S. L. Thomas & Thomas, 2004; Women's Commission for Refugee Women & Children, 2006). The chaos that follows armed conflict typically leads to disintegration in the social and political order, allowing human rights abuses, particularly gender-based violence, to flourish. During such struggles, women and girls suffer disproportionately as the targets of brutal acts of sexual violence (McKay, 1998; Swiss & Giller, 1993; Taback, Painter, & King, 2008; Ward et al., 2007).

Scholars have documented the worldwide use of sexual violence against women throughout the ages and across cultures, calling it a *weapon, strategy, instrument*, and *tool* (Arcel, 2002; Ferris, 2007; McKay, 1998; Pickup, 2001; Swiss & Giller, 1993). Until recently, however, there existed very limited research on the impact of conflict-related sexual violence on African women (Amowitz et al., 2002; Giller, Bracken, & Kabaganda, 1991; Swiss et al., 1998; Taback et al., 2008; Wagner, 2005; Ward et al., 2007).

In recent years, the research literature has begun to address the experiences of forced African female migrants in Western countries (Akinsulure-Smith, Ghiglione, & Wollmershauser, 2009; Carroll et al., 2007; Charlés, 2009; Guerin, Elmi, & Guerin, 2006; Loewy, Williams, & Keleta, 2002; McMichael & Manderson, 2004; Whittaker, Hardy, Lewis, & Buchan, 2005). For the purposes of this article, the term *forced migrant* refers to refugees, asylees, and asylum seekers who have fled their countries due to civil and political unrest. There has been no exploration, however, of the specific impact of sexual violence on these women as they rebuild their lives in new sociocultural environments, nor have the subsequent challenges for mental health service provision been addressed.

The goal of this article is to raise awareness among mental health professionals about the experiences of African women who have endured sexual violence during armed conflict and then become forced migrants. Drawing on clinical experiences gathered from therapeutic work with African female forced migrants in New York City, this article also highlights the challenges that prevent these women from seeking mental health services once they arrive in Western countries and discusses the need for culturally informed clinical interventions. These clinical experiences were gathered from two treatment settings, the Bellevue/NYU Program for Survivors of Torture (PSOT) and Nah We Yone (NWY). PSOT offers an integrated, multidisciplinary treatment approach to individuals and families subjected to human rights abuses, social and civil unrest, armed conflict, and refugee trauma (Akinsulure-Smith, 2007; Smith, 2007). NWY, a community-based, grassroots organization, served forced African migrants

in the metropolitan New York area from 1997 to 2010 (Akinsulure-Smith et al., 2009; Akinsulure-Smith & Jones, 2011).

Sexual Violence and Armed Conflict

The widespread use of sexual violence in conflict zones has been well documented (Ward et al., 2007). Many acts of sexual violence (including rape, gang rape, sexual slavery, and prostitution) are committed systematically and strategically to terrorize, punish, intimidate, and humiliate civilian women and girls from specific ethnic, religious, and political groups. Warring parties also use sexual violence to obtain information, demoralize men for failing to "protect their women," displace specific populations from their homelands, receive sexual gratification, and demonstrate power (Swiss & Giller, 1993; Ward et al., 2007; World Health Organization [WHO], 2002).

African women have reported horrific sexual violence (e.g., vaginal and/or anal penetration with foreign objects such as guns, knives and sticks). These acts are accompanied by repeated instances of physical brutality, such as beating and torture, and emotional sexual violence, including forced nudity, forced incest, witnessing violent sexual acts against others, sexual humiliation, and harassment (Amnesty International [AI], 2004a, 2004b, 2007; Amowitz et al., 2002; Human Rights Watch [HRW], 2002, 2003, 2007a, 2007b; Swiss et al., 1998). In deliberate defiance of cultural and religious norms (e.g., norms around incest), perpetrators of such violence often violate their victims in the presence of spouses, children, parents, relatives, or friends, who are forced to look on helplessly (McKay, 1998; Taback et al., 2008; Ward et al., 2007). Female survivors of sexual violence are particularly vulnerable to additional abuse at the hands of those who wield considerable power, especially during armed conflicts, including rebels, aid workers, community leaders, and peacekeepers. These women may actually be betrayed by the very people to whom they have turned for help (Ferris, 2007; Pickup, 2001).

The Impact of Sexual Violence

The consequences of sexual violence during armed conflict are profound and far-reaching. Sexual violence may continue to impact the physical and mental health of survivors long after the atrocities have been committed. Often, perpetrators of sexual violence set out to do far more than destroy survivors' sense of identity. Sexual violence is a tactic designed to "humiliate and terrorize" (Kumar, 2001, p. 11) members of certain ethnic, political, or religious groups. Acts of sexual violence are intended to dominate and control the victims and to devastate their families, communities, and societies. Because many women serve as caretakers of others, the impact of sexual violence during armed conflict extends beyond individual victims to their families and communities (Ward et al., 2007; WHO, 2002). In addition, armed conflict destroys community and social resources and wipes out many of the traditional avenues for healing such problems (Amowitz et al., 2002; HRW, 2002, 2003, 2007a, 2007b; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; McKay, 1998; Swiss & Giller, 1993; Taback et al., 2008; Ward et al., 2007).

Physical consequences. The physical effects are the most obvious consequence of sexual violence, more visible than the psychological and social consequences. Many female victims of sexual violence during armed conflict suffer from extensive gynecological damage such as traumatic fistula (tissue tears in the vagina, bladder, and rectum). Additional long-term medical complications affecting the reproductive system may include uterine prolapse (the descent of the uterus into the vagina or beyond), irregular periods, infertility, and miscarriages. Pain in the lower abdomen, uterus, and vagina; rashes; and sexual dysfunctions are further common physical sequelae of sexual violence.

Survivors also report a variety of genitourinary disturbances (e.g., incontinence, burning during urination, frequent urination, vaginal discharge, rectal bleeding). Trauma to the throat may occur in cases of forced oral sodomy. In addition, this population is at risk for HIV and other sexually transmitted diseases (STDs). Other physical symptoms may include soreness; bruising on arms, legs, and breasts; chronic aches and pains; and gastrointestinal irritability (e.g., stomach pain, nausea and vomiting, loss of appetite, diarrhea, and constipation). Victims also experience tension headaches, chronic fatigue, edginess or jumpiness, and disrupted sleep patterns (Arcel, 2002; Cohen, d'Adesky, & Anastos, 2005; HRW, 2003; Ward et al., 2007).

Psychological consequences. Whereas physical trauma is relatively easy to document, the enduring emotional and psychological effects of sexual violence during armed conflict are much harder to identify and address effectively (AI, 2007; HRW, 2003). Sexual violence survivors have been violated not only physically but also emotionally. Their safety and their very lives have been seriously threatened and disrupted. Often they have been subjected to multiple humiliating personal violations and instances of physical danger. As a result, their reactions can be extremely intense and very complicated. Furthermore, each individual copes with or responds to the trauma of sexual violence in her own way, based on her life experience, personality, and the particulars of the sexual violence.

The psychological consequences of sexual violence include intense feelings of terror, anger, anxiety, disbelief, and shame. Profound feelings of shame may add to a sense of hopelessness, helplessness, and distress. Sexual violence survivors also suffer from a loss of self-esteem; cognitive disturbances (e.g., difficulties with decision making, poor concentration, memory loss, confusion); behavioral changes (e.g., withdrawal from friends and family, sexual dysfunction); and neurovegetative symptoms (e.g., lack of energy, insomnia). Survivors of sexual violence during armed conflict may also contend with depression, detachment or numbness, and hyperarousal, classic symptoms of posttraumatic stress disorder (PTSD; Arcel, 2002; Krug et al., 2002; Swiss & Giller, 1993; Swiss et al., 1998; K. Thomas, 2007; Ward et al., 2007).

Social consequences. Sexual violence during armed conflict has significant social consequences for survivors. Many remain silent about their trauma because they fear stigmatization, rejection, and social exile by their families and communities. In many African cultures, survivors of sexual violence lose all marital prospects, bringing shame

on the entire family (AI, 2004b; HRW, 2002, 2007a). Impregnated survivors must often choose between an unsafe abortion and giving birth to an innocent child who will bear the scorn and wrath of the community (AI, 2004a, 2004b, 2007; HRW, 2002, 2003, 2007a, 2007b; Krug et al., 2002; K. Thomas, 2007; Ward et al., 2007). Rather than become social outcasts or be labeled as "damaged goods," many women may actively hide or deny the abuse. Most survivors do not seek redress for the crimes committed against them. Most victims do not come forward willingly, often waiting until their distress and suffering become unbearable or require medical attention (Ward et al., 2007).

Migration to the United States

The number of African immigrants in the United States (US) has grown from 35,355 in 1960 to 1.4 million in 2007. In many urban areas in the US, Africaa are among the fastest growing immigrant groups (Capps, McCabe, & Fix, 2011; Kent, 2007; Thomas, 2011). More than 75% of these immigrants have arrived since 1990. Roughly one third of all refugees and asylees admitted to the United States in 2007 were Africans (Terrazas, 2009).

The emotional suffering caused by sexual violence usually does not cease when the traumatic events end. Most African women victims of sexual violence during armed conflict endure years of severe psychological distress. By the time these displaced survivors arrive in the United States, many of them have already dealt with enormous physical and emotional disorientation stemming from lengthy family separations. They have also experienced many losses, including loss of professional or social status; loss of culture, language, and familiar social-cultural structures; loss of possessions and economic security; and loss of personal support systems and physical and emotional well-being.

Forced African female migrants contend with new issues adjusting to life in the West (Akinsulure-Smith et al., 2009; Robertson et al., 2006; Smith, 2007). Like many immigrants, they struggle with numerous economic, legal, linguistic, and cultural barriers (Gany & Thiel de Bocanegra, 1996); however, these women also bear the additional burdens of their traumatic histories. These stressors affect their daily existence in the form of constant fear, anxiety, depression, sleep disturbances, headaches, body aches, poor concentration, poor memory, low self-esteem, and sexual difficulties. The short-term or episodic nature of some of these problems may prevent women from seeking needed mental health services; however, these problems can have profound and long-lasting effects that may only surface after months or years (Akinsulure-Smith et al., 2009; Drachman, 1995; Gong-Guy, Cravens, & Patterson, 1991; Pan et al., 2006; Whittaker et al., 2005).

Barriers to Seeking and Utilizing American Mental Health Services

Forced African female migrants often feel disempowered by the challenges they face in the West. Emotional difficulties, family separations, and extensive losses make these

women less likely to seek appropriate services. They frequently underutilize the direct mental health services available to them in America due to multiple barriers, including limited language skills, economic and legal concerns, and cultural beliefs. For many Africans, stigma surrounds mental health issues. Mental health problems are typically viewed as

> one or a combination of the following: punishment from the gods for evil deeds, a wicked eye-look, a curse, witchcraft, an offence against the gods, a disruption of harmony in one's earlier life, "juju" (native charms), natural causes, break of taboo or native customs, a disruption of social relationships, angry ancestors, evil possession, possession by the devil, or an intrusion of objects. (Madu, 1997, p. 30)

Within the African cultural context, mental health problems are traditionally addressed through informal networks and cultural and religious practices or rituals. Extended family, friends, religious and spiritual leaders, community elders, leaders of secret societies, and traditional healers provide advice and support (Akinsulure-Smith et al., 2009; Charlés, 2009; Guerin et al., 2006; Loewy et al., 2002; Madu, 1997; McMichael & Manderson, 2004; Nwadiora, 1996; Robertson et al., 2006; Whittaker et al., 2005).

These traditional, culturally sanctioned avenues for help do not exist in the West. Furthermore, for the many African women whose countries lack formalized mental health services, the concept of mental health care is entirely new. Displaced African women who flee to the United States are usually unfamiliar with psychotherapy. When these women do learn about this option for help, their negative associations with such assistance may get in the way. They may view such assistance as an inappropriate and shameful solution to their problems. Discussing traumatic sexual experiences and their psychological effects with a stranger can be daunting for any woman, but this behavior is culturally prohibited for many Africans. As a result, many displaced African women must overcome multiple strong cultural barriers before seeking mental health services.

Lessons Learned From Clinical Work With African Female Survivors of Sexual Violence

Mental health professionals trained in Western models of intervention face numerous challenges in providing effective psychosocial support to displaced African women who have survived sexual violence during armed conflict. How can service providers offer services that take into consideration the women's cultural, social, and political realities while addressing their traumatic experiences and helping them meet their basic needs? How can service providers best assist these women in rebuilding their lives in a new cultural environment? How can professionals assist women who often cannot easily access psychosocial services due to linguistic and cultural barriers? How can service providers reach women who are so focused on their daily struggle for survival that they do not think they have time for mental health services?

Given the increasing numbers of displaced African women arriving in the United States, it is striking that there has not been more discussion of culturally informed interventions tailored to the psychosocial needs of this population. The limited literature about clinical services for forced African female migrants has discussed the importance of a range of modalities that draw on community and culture, along with religious and traditional practices, such as music, dance, food, and drink to promote emotional well-being (Akinsulure-Smith et al., 2009; Carroll et al., 2007; Charlés, 2009; Guerin et al., 2006; Loewy et al., 2002; McMichael & Manderson, 2004; Nilsson, Brown, Russell, & Khamphakdy-Brown, 2008; Pan et al., 2006; Robertson et al., 2006; Whittaker et al., 2005). To provide effective services for those women, mental health professionals must think sensitively yet creatively about culturally relevant techniques. Ultimately, the challenge for clinicians is to tap into the very strength and resilience that enabled the displaced African women to survive the devastation of armed conflict and sexual violence and make it to the West.

Recognition of Diversity of African Cultures and Geopolitics

Through my clinical work with this population, I have learned a number of important lessons. First and foremost, it is imperative that mental health professionals recognize the enormous diversity and heterogeneity among African cultures. Although certain ethnic groups may share similar customs, they are not monolithic. Too often, there is an assumption that all "Africans" share the same cultural and traditional customs and belief systems. Bearing this lesson in mind, each conflict (and the ways in which women have been targeted during that conflict) comes with its own significance. Learning about and understanding the geopolitical histories of a woman's region of Africa can provide crucial insights into her unique experiences, offer information about her struggles, and provide a means for building therapeutic alliances. For example, does she come from a country where women were specifically targeted for sexual violence, such as Sierra Leone? Here the "Rebels" (i.e., antigovernment forces) used child soldiers to explicitly target women and young girls for brutal acts of sexual violence (Amowitz et al., 2002; HRW, 2003; Medeiros, 2007). Is she from Liberia, a country where "Small Boys Units," ran amok (Medeiros, 2007), or the Congo, where women continue to be targeted (HRW, 2002)? In such conflicts, women have been targeted in uniquely specific ways. In Rwanda, it was women of a certain ethnic group, the Tutsis, who were the targets of sexual violence (HRW, 1996). Knowledge of the conflict's timeline and the client's knowledge regarding the current status of the conflict can offer additional pertinent information: Is the conflict over and has a tenuous peace been restored (e.g., Liberia, Rwanda, Sierra Leone)? Is the conflict still ongoing in parts of the country (e.g., Democratic Republic of Congo, Sudan, and Uganda)? Does the fighting continue to erupt intermittently (e.g., Côte d'Ivoire, Congo Republic)?

Understanding the Referral Source and Reason for Referral

As with any client, the referral source and the reason for referral can significantly influence the treatment process and outcome. When working with forced African female migrants

who have experienced sexual violence, one must be careful to understand the expectations of the referral source and the reasons for the referral. Women may seek treatment for a host of reasons and will present unique combinations of needs. One woman may be driven by her daily survival needs (e.g., to learn English, to cope with limited financial resources, to obtain housing and food, to navigate the complex asylum process); another client may wish to explore the multiple losses she has suffered (loss of country, family, community). Yet another may want to directly address her experiences of displacement and sexual violence. It is also important to distinguish between what a referral source perceives to be a client's needs and what the woman herself wishes to address.

> Ms. Z, a university-educated young woman from the Democratic Republic of Congo in her mid-30s, sought treatment at the insistence of her lawyer. Her attorney believed that mental health services would strengthen Ms. Z's asylum case by helping her immediately discuss her traumatic experiences in great detail, particularly those surrounding her abduction, captivity, and multiple rapes.

> While the referring attorney in this case was focused on gaining asylum for his client, his client was not yet ready to address those painful areas of her past. In fact, after the first two sessions, she disappeared from treatment. It was not until a year later, when her symptoms became too overwhelming for her to function, that she returned to treatment. When Ms. Z returned, several sessions were devoted to educating Ms. Z *and* her attorney about the therapeutic process, thereby adjusting expectations realistically.

Referrals for mental health services range from attorneys who push their clients to seek services because they believe that mental health services could strengthen their asylum cases, to women who themselves are troubled by their physical symptoms, to those whose acquaintances have expressed concerns about their poor psychosocial functioning.

> Ms. T, an illiterate woman in her early 20s from Sierra Leone, sought therapeutic services at the urging of an acquaintance who had become increasingly concerned about Ms. T's well-being. Although hesitant and reluctant at first, Ms. T's symptoms (e.g., nightmares, insomnia, flashbacks) were so disturbing to her that she was willing to follow-up with medical and psychological services to find relief. As the therapeutic alliance grew and treatment unfolded, Ms. T's long history of multiple gang rapes, abduction and captivity during the Sierra Leonean civil war became a significant part of our detailed and slow therapeutic work.

Due to feelings of shame and fears of stigma within the African immigrant community, those women who do seek services will rarely admit that they are experiencing mental health difficulties. In this case, it took someone else to encourage Ms. T. to seek services.

The Use of Psychoeducation

Psychoeducation about treatment and mental health services is one area that is often underappreciated. Through this work, I have come to appreciate the value of detailed

psychoeducation to help African women fully understand the concept and process of mental health services, before any type of therapeutic work begins. For women who come from a culture where the discussion of intimate problems is typically limited to the elders, religious leaders, or close family (Akinsulure-Smith et al., 2009; Charlés, 2009; Guerin et al., 2006; Loewy et al., 2002; Madu, 1997; McMichael & Manderson, 2004; Nwadiora, 1996; Robertson et al., 2006; Whittaker et al., 2005), the notion of sharing with a total stranger can be quite overwhelming. For many, a big fear is that someone from their community might find out about their "shameful" experiences. Needless to say, the women's fears of who will have access to this information can hinder the therapeutic process. I have had numerous women breathe a visible sigh of relief after repeated discussions regarding confidentiality laws.

> Ms. W, a young woman from Rwanda, admitted to difficulties with her concentration and worried about her forgetfulness. She also reported fears of men in uniform, bouts of debilitating sadness, and numerous genitourinary problems. During our sessions, she provided sketchy background information and rebuffed all attempts to gain any details. It was not until several months of revisiting her repeated questions regarding confidentiality (e.g., who would have access to the information we discussed?) that she casually mentioned that she had heard that colleges have access to this type of information when prospective students apply. Ms. W dreamt of going back to college but feared that the information from our sessions would go on her "record" and work to her disadvantage. Once this misunderstanding was cleared up, she began to share explicit details of her experiences of sexual violence during that armed conflict.

Concerns About Confidentiality

In my experience, directly and repeatedly addressing multiple concerns about confidentiality can serve to enhance trust when building therapeutic alliances. Once the issues of confidentiality have been addressed, it becomes important to offer a detailed explanation of how psychotherapy works, the expectations of the clinician (e.g., attendance at weekly, 50-min sessions), and the type of therapeutic interventions to be used (individual or group). Finally, offering detailed information about symptoms, particularly those pertaining to depressive or PTSDs, allows women to see that they are not alone, and are not "crazy," but simply experiencing normal reactions to experiences meant to destroy them.

Treatment Interventions

It is also important for clinicians to carefully consider the type of intervention they intend to use with this population. Although group treatment has been found to be effective with various traumatized forced migrants from Africa (Akinsulure-Smith, 2009); Akinsulure-Smith, 2012; Loewy et al., 2002; McMichael & Manderson, 2004; Smith, 2007; Whittaker et al., 2005), in my clinical experience, forced African female migrants who have endured sexual violence during armed conflict are typically reluctant to engage in group treatment. At PSOT, on two separate occasions, we developed

small groups (six-seven members) for forced African female survivors of sexual violence. In both cases, the groups were designed to (a) provide women who share a common experience of war and persecution-related sexual violence with a safe and nurturing space; (b) facilitate the reestablishment of ties with other women, thereby reducing social isolation; and (c) offer the women new opportunities for empowerment and to rebuild their lives. Whereas other therapy groups (e.g., the African Francophone Group, the English Speaking Group for African Men, and the Tibetan Group) flourished for several years, both of these attempts failed. Although the participants initially seemed engaged in group work, by the eighth session, despite reminder phone calls and several discussions, attendance had dwindled to low or no participants. Later on, during individual sessions, it became clear that when it came to addressing their experiences of sexual violence, the women preferred individual work. Although group treatment may offer substantial benefits in terms of building social support networks and teaching new coping skills, in my experience, this population appeared to be more comfortable in one-on-one individual treatment when addressing the trauma related to sexual violence.

Cultural Considerations

A number of cultural considerations should guide the approach to mental health service provision with this population. The integration of psychotherapy with religious or spiritual practices is not necessarily a part of training for clinicians trained in Western models; however, in my clinical experience, women have often asked to pray for guidance and strength at the end of sessions. It is important to acknowledge the role faith and prayer may play in these women's lives as they work toward recovery. Elements of religion and spirituality frequently offer a means of self-soothing, meditation, and meaning making.

> Ms. B, a devout Muslim woman in her early 30s, who was gang raped repeatedly during the Sierra Leonean civil war, struggled to engage in individual psychotherapy. She often disappeared from treatment for months at a time. Over time we noted that these disappearances happened when our therapeutic work became too overwhelming for her. She subsequently became flooded by her memories outside our treatment setting. Noticeable therapeutic breakthroughs and her ability to tolerate our sessions finally occurred when we were able to incorporate self-soothing techniques and rituals that drew on her strong Muslim faith. These involved her identifying and repeating to herself soothing scriptures from the Holy Koran. She eventually joined a larger Muslim community, which decreased her sense of isolation.

In addition to spirituality, cultural heritage and cultural means of healing may yield powerful tools in treatment.

> Initially, Ms. J., a 45-year-old woman from Sierra Leone was very clear about not wanting to discuss her sexual trauma. During the early years of the "rebel war" she had watched her home burn down; her child and husband had gone missing. She was very reluctant to

discuss any of these parts of her past. As a result, for a long time treatment focused on daily survival in New York City and the stress revolving around her asylum claim. Through the course of treatment it became obvious that Ms. J's Sierra Leonean cultural traditions were very important to her; these discussions became central to her therapy. Eventually, by incorporating her culture's mourning traditions into our sessions, Ms. B. was able to feel spiritually connected to her missing family members and make peace with those losses. Despite feeling she had lost everything, she came to realize that she could keep alive rituals from her home country and her previous life. Using some of those rituals in our work allowed us to find a safe space to begin to discuss and unpack her traumatic rape experience and to prepare her for her asylum hearing and eventual testimony in Immigration Court.

Clinical Flexibility

Flexibility with regard to the scheduling and time boundaries of sessions has proved critical to my work with this population. For example, in Sierra Leone, impromptu visits are a culturally acceptable way to have meetings. Incorporating this cultural norm into treatment became essential with Sierra Leonean clients. A number of women I worked with were unable to attend regularly scheduled weekly therapy sessions or to stay for the full 50-min session. Reasons offered have included transportation problems (at PSOT needy clients are given Metro cards to help them keep their appointments), unstable housing situations, and conflicting appointments (e.g., meeting with an attorney); however, when the client and I have been able to fully explore the reason, the real reason often turns out to be due to overwhelming memories. For example, for one woman, her sessions and the memories they evoked were so intense that she was scared away for a few months.

Such flexibility also means that as a clinician working with this population, it is vital to recognize that treatment can be inconsistent and progress may occur in uneven steps. Clinicians, however, may be able to make creative use of this inconsistency.

> Because Ms. X, a woman in her 40s from Liberia, was very distrustful and ashamed of her experiences, rapport building was especially slow. Because of this, in the beginning, treatment focused on seeking practical resources, such as food pantries and seasonal clothing. The foundation of trust that resulted from this work later enabled us to address Ms. X's experiences at the hands of "small boys" during the Liberian war; her separation from and loss of her family; and the multiple gang rapes she endured.

Role of Shared African Heritage

In my work with this population I have been repeatedly reminded of how important it is for the clinician to have a grounded sense of how her own gender and racial and cultural identity can influence the clinical work with this population. I am an African immigrant woman from a war-torn country; my clients often reported that they found it meaningful to have an African woman as their therapist. Many spoke of feeling understood by someone whom they viewed as sharing some part of their cultural

heritage. Many of these women felt that I served as an African female role model, mentor, and guide to them as they navigated this new cultural experience. I have also been reminded of the importance of clinician self-care as work with this population can place multiple stressors on the clinician.

Support System for Clinical Providers

For those who work with trauma survivors, Herman (1992) speaks to the importance of a support system for counselors that includes "a safe, structured and regular forum for reviewing her clinical work" (p. 151). In my various settings, I have learned that regular supervision as well as a peer support group offer a safe place to explore reactions while discussing technical and theoretical concerns related to the care of this population.

Experiences Shared by Survivors

Despite the significant differences in treatment of the women with whom I have worked, there have been common elements. Many of the survivors whom I have worked with first needed to explore themes of safety, loss (family, identity, status, culture), grief and mourning, shame and anger, and cultural adaptation (i.e., becoming an African woman in America). Often, it was too difficult to discuss the sexual violence they had suffered because they had not previously disclosed their rapes to anyone, despite having heard stories of other women who had shared their experiences. Even when seeking asylum, some women omitted this vital information on their asylum applications. All of the women I worked with expressed concern about being viewed as spoiled or damaged goods by their communities. Finally, every one of these cases required extensive groundwork in the form of trust building before addressing any traumatic material. It should also be clear that each case has needed other services beyond the clinical work. Thus, having access to multidisciplinary services is vital.

In treatment with this population, success for each case needs to be judged differently. For some, learning to cope with debilitating symptoms is victory. There is no desire to address sexual trauma other than in preparation for the asylum hearing. Others are more willing to use mental health services to examine sexual trauma experiences over an extended period of time, gaining insight into strengths and coping abilities. For still others, mental health services provide a space in which to discuss strong religious convictions and use them as a support.

Considerations for Clinical Work With Forced African Female Migrants

Importance of Outreach and Partnerships With Local African Communities

Mental health professionals must develop collaborative, trusting relationships with their local African immigrant communities. For displaced African women who have

experienced sexual violence and who come from collectivistic cultures, it is critical to incorporate community and social networks into the treatment process. Thus, to offer effective mental health services to these women, service providers need to start by identifying the displaced African communities in their areas. Mental health professionals should educate themselves about the countries and regions of the continent from which these survivors come. They should find out who their local community leaders are, whether they have a voice, and what they see as these women's primary needs. A good way to do this is to locate and foster connections with grassroots and community-based organizations that provide services to African immigrants. Mental health professionals can help such organizations by offering workshops to teach the immigrant communities about adjustment challenges and traumatic experiences. In those workshops, clinicians can normalize the range of reactions that the displaced African women may have, while also informing them about the types of services available and how to access them. An example of this is NWY, a grassroots, community-based organization that offered "Therapeutic Outings." Through community brunches and other activities, NWY's clinical staff incorporated community and culture into clinical work and provided much-needed therapeutic services (Akinsulure-Smith et al., 2009; Akinsulure-Smith & Jones, 2011).

In order for women to take advantage of services, they must be aware of their availability. The importance of targeted outreach and information about services, where and how to access them, cannot be understated. Such information can be provided in areas where African immigrant women meet, such as community places of worship, African markets and restaurants, braiding salons, and local community organizations. Information can also be disseminated via local African newspapers and radio programs, and for those who have access, various social networking outlets.

Clinical Flexibility

In addition to drawing on displaced African women's cultural and religious heritage to inform and support the therapeutic process, clinicians must employ a flexible approach—a willingness to move outside traditional Western ideas of therapy. The role of clinician may extend beyond the 50-min hour to that of interpreter, expert witness (during immigration proceedings), advocate, and cultural translator (e.g., explaining American holidays). Furthermore, it is important for mental health professionals to recognize that working with displaced African women rarely progresses in a simple linear fashion. Treatment can move in starts and stops. These zigzags can occur for both practical reasons, such as women foregoing sessions to take advantage of rare work opportunities, or to spend time preparing for and attending asylum hearings, and for emotional reasons, such as women needing time to become comfortable with therapy before revealing traumatic material. Finally, it is essential to provide psychoeducation during treatment so women can learn about the common mental and physical effects of their traumatic experiences and what services, ideally both individual and group, can address those reactions.

Holistic Approach to Care

Mental health professionals treating forced African female migrants need to take a holistic approach to their care. It is important for these women to receive comprehensive services, ideally from an interdisciplinary treatment team in one location. Language classes as well as legal, social, and medical services should be provided. (Unfortunately for displaced African women who do not yet have their official asylum and work authorization documents or "papers," access to medical services may be limited due to their unresolved immigration status.) Given that many of these women have experienced various physical and emotional traumas, they may benefit from having culturally sensitive medical professionals, trained in women's issues, and work in conjunction with their mental health clinicians. These women also need to be connected with asylum, food, clothing, and housing assistance. Developing a cadre of proficient interpreters is crucial to the provision of these services to patients who speak little or no English (Akinsulure-Smith, 2007; Gany & Thiel de Bocanegra, 1996; O'Hara & Akinsulure-Smith, 2011).

Conclusion

Armed conflict has had devastating consequences in many African countries, including increased sexual violence toward, and displacement of, hundreds of thousands of African women. Their needs deserve special attention, for these women carry not only the burden of their distressing histories but also their daily struggles to survive in a new culture. To provide appropriate support and care to these women, it is important to identify who they are, what their needs are, and what their cultural, religious, and spiritual traditions are. This knowledge will allow mental health professionals to offer culturally relevant psychological services. Clinicians need to engage African female survivors of war-related sexual violence in ways that will reduce their sense of isolation, normalize their experiences, and enhance their ability to cope with their past and current stressors.

Standard Western models of intervention alone may not be suitable or sufficient to meet the needs of forced African women migrant survivors of sexual violence during armed conflict. Mental health providers must be willing to move beyond traditional Western treatment techniques to encompass traditional African domains of strength and resilience, namely, social and community networks; however, more research is needed to fully understand the social factors that support displaced African women. In addition to reestablishing and strengthening these women's ties to their communities, clinicians must also help forced African women migrants access the medical, social, legal, and educational systems at all levels. Psychotherapy must be provided in conjunction with these other comprehensive supportive services in order for forced African female migrants to better their lives. It is impossible to improve their psychological and emotional states without also addressing their basic needs (e.g., food, shelter) and improving their physical, legal, educational, and financial status.

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References

Akinsulure-Smith, A. M. (2012). Using group work to rebuild family and community ties among displaced African men. *Journal for Specialists in Group Work*, *23*(2), 95-112.

Akinsulure-Smith, A. M. (2007). Use of interpreters with survivors of torture, war, and refugee trauma. In H. E. Smith, A. S. Keller, & D. W. Lhewa (Eds.), *". . . Like a refugee camp on First Avenue": Insights and experiences from the Bellevue/NYU Program for Survivors of Torture* (pp. 82-105). New York: Bellevue/NYU Program for Survivors of Torture.

Akinsulure-Smith, A. M., Ghiglione, J. B., & Wollmershauser, C. (2009). Healing in the midst of chaos: Nah We Yone's African women's wellness group. *Women & Therapy*, *32*, 105-120.

Akinsulure-Smith, A. M., & Jones, W. L. (2011). Nah We Yone—A grassroots community based organization in New York City: Successes, challenges, and lessons learned. *International Journal of Migration, Health, and Social Care*, *7*, 44-57.

Amnesty International. (2004a, November 10). *Central African Republic: Five months of war against women* (AI Index: AFR 19/001/2004). Retrieved from http://www.amnesty.org/fr/library/asset/AFR19/001/2004/fr/30341d13-d57e-11dd-bb24-1fb85fe8fa05/afr190012004en.pdf

Amnesty International. (2004b, July 19). *Sudan, Darfur: Rape as a weapon of war: Sexual violence and its consequences* (AI Index: AFR 54/076/2004). Retrieved from http// http://www.amnesty.org/en/library/info/AFR54/076/2004

Amnesty International. (2007, March 15). *Côte d'Ivoire—Targeting women: The forgotten victims of the conflict* (AI Index: AFR 31/001/2007). Retrieved from http://www.unhcr.org/refworld/docid/45ffa4dd2.html

Amowitz, L. L., Reis, C., Lyons, K. H., Vann, B., Mansaray, B., Akinsulure-Smith, A. M., et al. (2002). Prevalence of war-related sexual violence and other human rights abuses among internally displaced persons in Sierra Leone. *Journal of the American Medical Association*, *287*, 513-521.

Arcel, L. T. (2002). Torture, cruel, inhuman, and degrading treatment of women: Psychological consequences. *Torture*, *12*(1), 5-16.

Arthur, J. A. (2008). *The African Diaspora in the United States and Europe: The Ghanaian experience*. Burlington, VT: Ashgate.

Capps, R., McCabe, K., & Fix, M (2011). *New streams: Black African migration to the United States*. Washington, DC: Migration Policy Institut. Retrieved from http://www.migrationpolicy.org/pubs/AfricanMigrationUS.pdf

Carroll, J., Epstein, R., Fiscella, K., Gipson, T., Volpe, E., & Jean-Pierre, P. (2007). Caring for Somali women: Implications for clinician-patient communication. *Patient Education and Counseling*, *66*, 337-345.

Charlés, L. L. (2009). Home-based family therapy: An illustration of clinical work with a Liberian refugee. *Journal of Systemic Therapies*, *28*, 36-51.

Cohen, M. H., d'Adesky, A.-C., & Anastos, K. (2005). Women in Rwanda: Another world is possible. *Journal of the American Medical Association*, *294*, 613-615.

Drachman, D. (1995). Immigration statuses and their influence on service provision, access, and use. *Social Work*, *40*, 188-197.

Ferris, E. G. (2007). Abuse of power: Sexual exploitation of refugee women and girls [Comparative perspectives symposium: Women in refugee camps]. *Signs, 32,* 584-591.

Gany, F., & Thiel de Bocanegra, H. (1996). Overcoming barriers to improving the health of immigrant women. *Journal of the American Medical Women's Association*, *51*, 155-160.

Giller, J. E., Bracken, P. J., & Kabaganda, S. (1991). Uganda: War, women, and rape. *Lancet*, *337*:, 604.

Gong-Guy, E., Cravens, R. B., & Patterson, T. E. (1991). Clinical issues in mental health service delivery to refugees. *American Psychologist*, *46*, 642-648.

Guerin, P., Elmi, F. H., & Guerin, B. (2006). Weddings and parties: Cultural healing in one community of Somali women. *Australian e-Journal for the Advancement of Mental Health*, *5*(2), 105-112. doi:10.5172/jamh.5.2.105

Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.

Human Rights Watch. (1996, September 24). *Shattered lives: Sexual violence during the Rwandan genocide and its aftermath*. Retrieved from http://www.hrw.org/node/78333

Human Rights Watch. (2002, June 20). *The war within the war: Sexual violence against women and girls in Eastern Congo* (Citation No. 2769). Retrieved from http://www.unhcr.org/refworld/docid/3d199ffd4.html

Human Rights Watch. (2003, January 16). *"We'll kill you if you cry": Sexual violence in the Sierra Leone conflict* (Report No. A1501). Retrieved from http://www.unhcr.org/refworld/docid/3f4f595b6.html

Human Rights Watch. (2007a, September 14). *Central African Republic: State of anarchy: Rebellion and abuses against civilians* (Report No. A1914). Retrieved from http://www.hrw.org/en/reports/2007/09/13/state-anarchy

Human Rights Watch. (2007b, August 2). *"My heart is cut"—Sexual violence by rebels and pro-government forces in Côte d'Ivoire* (Report No. A1911). Retrieved from http://www.unhcr.org/refworld/docid/46b715c82.html

Kent, M. M. (2007). Immigration and America's Black population. *Population Bulletin*, *62*(4). Retrived from http://69.63.135.52/pdf07/62.4immigration.pdf.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (Eds.). (2002). *World report on violence and health*. Retrieved from http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf

Kumar, K. (2001). Civil wars, women, and gender relations: An overview. In K. Kumar (Ed.), *Women and civil war: Impact, organizations, and action* (pp. 5-26.). Boulder, CO: Lynne Rienner.

Loewy, M. I., Williams, D. T., & Keleta, A. (2002). Group counseling with traumatized East African refugee women in the United States: Using the Kaffa ceremony intervention. *Journal for Specialists in Group Work*, *27*, 173-191.

Madu, S. N. (1997). Traditional healing systems and (Western) psychotherapy in Africa. In S. N. Madu, P. K. Baguma, & A. Pritz (Eds.), *African traditional healing: Psychotherapeutic investigations* (pp. 27-40). Kampala, Uganda: Access Communications.

McKay, S. (1998). The effects of armed conflict on girls and women. *Peace and Conflict: Journal of Peace Psychology*, *4*, 381-392.

McMichael, C., & Manderson, L. (2004). Somali women and well-being: Social networks and social capital among immigrant women in Australia. *Human Organization*, *63*, 88-99.

Medeiros, E. (2007). Integrating mental health into post-conflict rehabilitation: The case of Sierra Leonean and Liberian "Child Soldiers." *Journal of Health Psychology*, *12*, 498-504.

Nilsson, J. E., Brown, C., Russell, E. B., & Khamphakdy-Brown, S. (2008). Acculturation, partner violence, and psychological distress in refugee women from Somalia. *Journal of Interpersonal Violence*, *23*, 1654-1663.

Nwadiora, E. (1996). Therapy with African families. *Western Journal of Black Studies*, *20*(3), 117-124.

O'Hara, M., & Akinsulure-Smith, A. M. (2011). Working with interpreters: Tools for clinicians conducting psychotherapy with forced immigrants. *International Journal of Migration, Health, and Social Care*, *7*, 33-43. doi:10.1108/17479891111176287

Pan, A., Daley, S., Rivera, L. M., Williams, K., Lingle, D., & Reznik, V. (2006). Understanding the role of culture in domestic violence: The Ahimsa Project for Safe Families. *Journal of Immigrant and Minority Health*, *8*, 35-43.

Pickup, F. (with Williams, S., & Sweetman, C.). (2001). *Ending violence against women: A challenge for development and humanitarian work*. Oxford, UK: Oxfam GB.

Robertson, C. L., Halcon, L., Savik, K., Johnson, D., Spring, M., Butcher, J., et al. (2006). Somali and Oromo refugee women: Trauma and associated factors. *Journal of Advanced Nursing*, *56*, 577-587.

Smith, H. E. (2007). Multicultural issues in the treatment of torture and refugee trauma: Toward an interactive model. In H. E. Smith, A. S. Keller, & D. W. Lhewa (Eds.), *". . . Like a refugee camp on First Avenue": Insights and experiences from the Bellevue/NYU Program for Survivors of Torture* (pp. 39-62). New York: Bellevue/NYU Program for Survivors of Torture.

Swiss, S., & Giller, J. E. (1993). Rape as a crime of war: A medical perspective. *Journal of the American Medical Association*, *270*, 612-615.

Swiss, S., Jennings, P. J., Aryee, G. V., Brown, G. H., Jappah-Samukai, R. M., Kamara, M. S., et al. (1998). Violence against women during the Liberian civil conflict. *Journal of the American Medical Association*, *279*, 625-629.

Taback, N., Painter, R., & King, B. (2008). Sexual violence in the Democratic Republic of the Congo. *Journal of the American Medical Association*, *300*, 653-654.

Takougang, J. (2003). Contemporary African immigrants to the United States. *Irinkerindo: A Journal of African Migration*, *2*, 1-15.

Takyi, B. K. (2002). The making of the second diaspora: On the recent African immigrant community in the United States of America. *Western Journal of Black Studies*, *26*, 32-43.

Terrazas, A. (2009, February 10). *African immigrants in the United States* (Migration information source: Fresh thought, authoritative data, global reach). Retrieved from http://www.migrationinformation.org/USfocus/print.cfm?ID=719

Thomas, K. J. A. (2011). What explains the increasing trend in African emigration to the U.S.? *International Migration Review*, *45*, 3-28.

Thomas, K. (2007). Sexual violence: Weapon of war. *Forced Migration Review*, *27*, 15-16.

Thomas, S. L., & Thomas, S. D. M. (2004). Displacement and health. *British Medical Bulletin*, *69*(1), 115-127.

Wagner, J. (2005). The systematic use of rape as a tool of war in Darfur: A blueprint for international war crimes prosecutions. *Georgetown Journal of International Law*, *37*, 193-244.

Ward, J., Horwood, C., McEvoy, C., Shipman, P., & Rumble, L. (2007). *The shame of war: Sexual violence against women and girls in conflict*. Retrieved from http://www.eldis.org/assets/Docs/31252.html

Whittaker, S., Hardy, G., Lewis, K., & Buchan, L. (2005). An exploration of psychological well-being with young Somali refugee and asylum-seeker women. *Clinical Child Psychology and Psychiatry*, *10*, 177-196.

Women's Commission for Refugee Women & Children. (2006, February). *Displaced women and girls at risk: Risk factors, protection solutions and resource tools*. Retrieved from http://reliefweb.int/sites/reliefweb.int/files/resources/DF67C6D0045ABAEEC1257129005C5929-Displaced%20Women.pdf

World Health Organization. (2002). *World report on violence and health*. Geneva, Switzerland: Author. Retrieved from http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf

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