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Women's Voices: Gender Violence and Sexual Trauma among Internally Refugees in the Democratic Republic of the Congo

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ABSTRACT

Background: The study explores the impact of sexual violence and trauma on women living in a refugee camp in Democratic Republic of Congo. The influence of multiple adversities that Congolese women experience long-life (mainly extreme poverty, war, forced migration) and cultural factors (gender disparity, forced marriages, normalized intimate violence, etc.) which link to sexual violence in those territories are illustrated.

Methods: The study adopts a narrative research method, through interviews conducted with four raped women who screened positive at the Refugee Health Screener-15 for poor mental health (anxiety, depression, and PTSD).

Results: The devastating manifestations of sexual trauma on women's health emerge, particularly the core symptoms of the Complex Post Traumatic Stress Disorder (CPTSD) and Disturbances in Self-Organization (affect dysregulation, damaged self-image, interiorized rape stigma, disturbed social relationships, loss of meaning in life, hopelessness).

Conclusions: The need to assume a culturally sensitive approach to understand both the hidden suffering of women, and the barriers limiting access to health services in low resource/adverse settings are discussed.

Keywords: Internally refugee women; gender violence; sexual trauma; Complex Post-Traumatic Stress Disorder; interviews.

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Introduction

*«I have ceased to exist since I was raped
and now I am convinced that there is nothing in my life
will ever be the same as before,
I have lost my dignity which was all I had»*

The narratives reported here were collected in a refugee camp near Goma in the Democratic Republic of Congo (DRC), in August 2024, few weeks before the last ongoing offensive by M23 against the government forces resulting in Goma occupation (Wikipedia, 2025). Goma is the capital of the province of North Kivu, a territory located around the great lakes of the East African Rift Valley which has been the scene of armed conflicts between different factions since 1993, with millions of victims and displaced people (HCDH, 2010; Yotama & Yotama, 2021). Onana (2023) reports that since 1997, Congo, particularly the Kivu region, has counted 10 million deaths due to the war, 500,000 women raped, and 110,000 km² of land stripped and illegally exploited. Over the decades, the Lake Kivu region has witnessed the genocidal conflict in Rwanda in 1994 and then suffered clashes between national armies and many armed ethnic and tribal groups that continue to this day, resulting in hundreds of thousands of internally displaced persons (IDPs). Many refugee camps were located around Goma; they hosted many displaced people who lived in extremely precarious humanitarian conditions (Neuman, 2023). Only in the period 7-18 November 2024, the Goma camps hosted 143,918 new IDPs: 63,921 were in the Lac Vert/Bulengo camp alone, where the study was conducted, 99.7% of IDPs were displaced by armed conflict (IOM, 2024).

Forced displacement and stress for migration (Osman et al., 2024), together with additional traumatic loss-life events (e.g., exposure to violence, kidnappings, death family members, and cruelties), have serious consequences on the mental health of refugees. Studies report a high incidence of depression, anxiety and post-traumatic stress disorder (PTSD) among African refugees, with higher prevalence of PTSD in people exposed to war and ethnic conflicts (30%) as compared to those living in not involved regions (8%; Ng et al., 2020). The estimate incidence of PTSD is 40% in Congo (Veling, Hall, & Joosse, 2013; 22% in Sub-Saharan Africa; Ng et al., 2020), with a greater risk in women than in men (Idemudia et al., 2013; Mhlongo et al., 2018; Ndungu et al., 2020; Taheri et al., 2024). Youth girls and women experience multiple distressing circumstances, including illiteracy and school dropout, malnutrition, limited access to basic health services, discrimination, early or forced marriage, abortion, intimate violence that increase the risk for psychological disorders (Mukwege, 2021; Otita Likongo et al., 2022; Tadesse et al., 2024). Particularly, gender-based violence (Muluneh et al., 2020; Wyatt et al., 2017) is widespread in many provinces of Sub-Saharan Africa, particularly in rural areas, with devastating consequences on women's health.

Understanding female-specific trauma

A meta-analysis (Tadesse et al., 2024) estimates 48.2% the prevalence of gender-based violence among IDPs in Africa. Particularly sexual violence is a serious humanitarian emergency and a "silent epidemic" (Muluneh et al., 2020) among women, both as a form of intimate violence (which is suffered by more than two out of five women; Muluneh et al., 2020) as ethnic rape by armed groups (Mukwege, 2021). The atrocities experienced since childhood lead women to suffer violence as part of their lives, even forced prostitution and rape which make women a high-risk group for developing PTSD (Mhlongo et al., 2018; Wyatt et al., 2017). The victims of sexual assault manifest intrusions (e.g., unwanted memories or nightmares with trauma content), avoidance (i.e., situations that reactivate the emotional distress), hypervigilance (e.g., persistent perception of threat), and alterations in cognitions and mood (e.g., attention and planning, trauma-related emotions such as fear, shame, etc.) as typical symptoms of PTSD (American Psychiatric Association, 2022). In addition, in rape survivors a condition defined as Complex PTSD occurs. It describes the serious consequences of repeated and prolonged traumas over time, among which child abuse, intimate partner violence, sexual assault, community violence up to torture and genocide (World Health Organization [WHO], 2019). The devastating consequences for the person – defined as “Disturbances in Self-Organization” (DSO) – are grouped into three symptom clusters (*see* Table 1): (a) affect dysregulation (e.g., sadness and anger, feeling inconsolable crying), (b) difficulty in relationships (e.g., social withdrawal), and (c) negative self-concept (e.g., loss of identity, feeling permanently damaged, helplessness). According to ICD-11 (WHO, 2019), these manifestations, together with the core symptoms of PTSD, define the Complex PTSD (CPTSD). In rape survivors, the self-image remains irreparably damaged by the sexual trauma, as it results from the testimony, at the beginning of this introduction, of one of the women interviewed in this study. Furthermore, helplessness and social stigma (Verelst et al., 2014) increase the suffering of women, who live in despair for having completely lost the hope and meaning of life. When multiple stressful experiences endure over time (abandonment and stigma, insecurity, violent death of loved ones, conflicts for war), sexual trauma can lead to serious health outcomes, including depression and suicide (Bryant-Davis et al., 2010; Kuupiel et al., 2024; Lambert et al., 2024; Ndungu et al., 2020).

Symptom cluster	
Affect dysregulation	Anger
	Constant sadness
	Aggression
	Unusual crying
	Numbness
	Risky behaviors
	Difficulty to calm down
Negative self-concept	Shame
	Guilt
	Worthlessness
	Helplessness
	Loss of identity
	Self-hatred
	Permanently damaged
Feeling like a failure	
Disturbed relationships	Social withdrawal
	Difficulty in relationships
	Mistrust
	Feeling distant
	Negative feeling
	Conflicts
Altered system of meaning	Hopelessness
	Change in values
	Lack of life meaning

Table 1. Disturbances in Self-Organization (DSO) symptom clusters (adapted from Bovey et al., 2024).

Aim of the study

The current study focuses on female-specific trauma through the narratives of four internally refugee women in DRC. The study adopts a narrative research method based on personal story telling for two main reasons. First, qualitative studies focusing on the mental health status among Congolese women are scarce, with some exceptions (e.g., *see* Kandemiri, 2019; Mukwege, 2021). Secondly, narratives unveil how cultural factors influence the way people experience the trauma and its consequences (Bouzidi, 2017; Bovey et al., 2024). In fact, the core symptoms of the PTSD are common across cultures (Patel & Hall, 2021), but individual, community or ethnic factors, such as culture-specific strategies of coping or emotion display rules (Greer, 2011; Bovey et al., 2024), mediate the responses to adverse experiences. In addition, since cultural meanings shape how people interpret the Self (e.g., woman's identity or the value of virginity; Mukwege, 2021), the family and the social relations (e.g., forced marriages as normative, rape as a disgrace for the whole family; Bouzidi, 2018), a cultural-sensitive (or emic; Heim et al., 2022) approach is crucial for comprehending trauma related to sexual violence. The objective is to capture from the women's voices their hidden suffering, the losses and the consequences of the atrocities they experienced by putting them in the clinical framework of the Complex Post Traumatic Stress Disorder (CPTSD).

Method

The context

The semi-structured interviews were collected as a part of a broader research project on mental health status among internal refugees at Goma (DRC). At the time of writing this paper, preliminary quantitative data were analyzed on 50 women (18-68 y.o., $M_{\text{years}} = 30.5$, $SD_{\text{years}} = 12.4$) of which 42 (84%) resulted positive at the Refugee Health Screener-15 (RHS-15; Hollifield et al., 2013) for poor mental health (anxiety, depression, and PTSD). Among these women, 38 (95%; 10 of them did not respond) declared having suffered violence or torture (60% only once, 32.5% more than twice, 2.5% several times in the same day); furthermore, 33 directly witnessed to rape or murder against a close relative (44%) or a loved person (22%). At the end of completing the questionnaires, that were administered orally in French or local language (Swahili) by the health care personnel, women (who had responded positively to previous items on violence/rape) were asked if they were willing to continue narrating their experience.

Procedure

After the oral informed consent was obtained, the interviews took place at the Health Centre in a private place (called the “room of hope”, in Swahili *chumba ya matumaini*). The interviewer introduced himself as a master’s student in clinical psychology and, also, as a Roman Catholic priest. This last condition, together with an empathic listening, probably provided additional assurance and enabled women to feel protected in telling their traumatic experiences. The opening instructions were: “What happened to you? Can you share your experience? We know it is not easy for you, because of suffering you are experiencing. But we are here to listen to you, without judging you, and to bring relief to your worries”. Other open-ended questions were posed flexibly during the interviews around common topics (health before and after the violence, daily activities and sleeping, self-perception as a woman, family relationships, and community life).

The study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of the [Psychological Research and Intervention Center (CeRIP), University of Messina (protocol code 96468/2024) on July 30, 2024. Informed consent was obtained from all subjects involved in the study.

Narrative Analysis

In this study, the thematic analysis emerging from storytelling was conducted in four interviews. The contents were grouped into themes, but their sequence is not always uniform among the four cases

because the personal flow of memories and experiences was respected. In addition, the correspondences between what the women reported and the symptoms of the PTSD and CPTSD (Table 1) were sought. To respect privacy, the women's names have been changed, and only some personal data (such as age or family status) useful to understand their life experiences have been cited. Conversely, the authors have chosen to entirely report the description of the sexual assault – in Swahili, *ubakaji* (rape) or *ku kubakwa* (to be raped) – following the women's narrative.

In the thick bush (Narrative 1)

Chekanabo (44 y.o.) was born into a very poor family, and she interrupted her studies after her father's death. After her husband was killed by bandits, the looting of all her valuables and the death of her father-in-law who had provided for her and her 5 children, Mrs. Chekanabo's life was marked by concerns. *"The death of my father-in-law was unbearable for me, as he was the last person I could rely on after losing my husband and all our household belongings."* The daily difficulties intensified and Mrs. Chekanabo struggled to meet even the basic needs of her children. The situation she found herself in was truly shocking.

With an incoherent speech, her disheveled clothes and unkempt hair, Mrs. Chekanabo appeared in difficulty at the beginning of the interview. After the interviewer introduced himself and explained the purpose of the interview, she became trusting, saying, *"Ask me your questions and I will try to answer them."*

Circumstances of the rape

To feed her children, Mrs. Chekanabo had only one way: to go into the bush to collect firewood to sell in the neighborhood. She went out with other women and come home late at night, but sometimes the next day. One day [she doesn't remember the date] around 1:00 p.m., while she was in the bush, something worse happened to her (Mrs. Chekanabo tells with shame and sadness): *"Being tired from the weight of the firewood we were carrying, three of us women had to put the bundles down to catch our breath. While we were resting, armed men burst in and forced us into the bush. They told us they would kill anyone who dared to refuse or scream. Since I was tired and hungry, I walked slowly, so to make me walk faster, I was slapped, had rifle barrels shoved into my back, and was pushed. When we arrived at a place far from the path, they separated us like goats for slaughter. Without any help, two of these bandits tore off all my clothes and took turns committing their painful act. I don't know how to describe this scene; it's indescribable, terrifying."* While this act was taking place, Mrs. Chekanabo was terrified and stunned: *"I know when they started, but when they finished and left, I don't know. It was as if I had lost consciousness."*

Health condition and negative self-concept

Mrs. Chekanabo reports that her health was not 'very good' before the sexual assault, but it was not as concerning as it has been recently: *"At first, when I didn't know how to meet my children's needs, it caused me a great emotional disturbance (palpitations, for example). But as the days went by, I forced myself to understand the situation and accept it as it was."* But then she adds: *"the incident made me more vulnerable"*, the rape accentuated the fears about the future and damaged her identity as a woman: *"If no one came to my aid before I was raped, who will now, in this situation where I am no longer like other women?"*

Disturbed interpersonal relationships

Social relationships deteriorated as the traumatic events accumulated: the violent death of her husband, the looting of his property, and the conditions in which she was raped led her to harbor negative beliefs and mistrust about the community: *"I can no longer trust anyone, the world is evil and dangerous."* These beliefs led her to self-isolation and to suspect that some people around her were the perpetrators of the violence. *"I no longer trust people, especially men."* Since she no longer trusts the people around her, when she sees her friends, she thinks they are talking negatively about her.

Symptoms of PTSD

Mrs. Chekanabo relives the last event as it happened, not only through the thoughts or images that invade his mind, but above all through terrifying dreams: *"I dream of being killed, of being chased by armed men, of being tortured and raped."* She avoids external situations, such as people (whom she perceived as negative), places, activities, and conversations that trigger memories of thought or emotions associated with her trauma.

Raped and abandoned (Narrative 2)

Dawa (32 y.o.) comes from a very poor family (she is fourth among four females and one male siblings), she is illiterate and was married illegitimately¹. The man abandoned her with their four children; she has been living in the camp for 2 years thanks to the help of humanitarian organizations. Barefoot, with dirty clothes and unkempt hair, Mrs. Dawa showed an incoherent speech and an altered emotional state. She initially had difficulty talking about the event, but as soon as she discovered that the interviewer (a priest) was there to listen to her suffering – and that this would bring her some relief – she began to speak confidentially.

Circumstances of sexual violence

¹ She was cohabiting without being married and the man had not paid the dowry that makes the marriage official in Congolese society.

Mrs. Dawa was the victim of a rape perpetrated by three-armed men 4 years ago. *"Since it had been two days since I had found anything to feed my children, I decided to go with the other women into the woods to carry some embers. It was during that night that I experienced my misfortune,"* she said, with sadness and tears in her eyes. At the beginning of the interview, Mrs. Dawa was ashamed to talk about the event, avoiding looking at the interviewer: *"It's hard for me to talk about my rape story; what I went through is catastrophic, I struggle to express it."* While three men took turns raping her, threatening to kill her if she cried out, Mrs. Dawa experienced death: *"During this painful act, I felt as if I were dead."* This threat, also linked to the fear of dying, deeply affected and stunned her during the sexual violence: *"When it was the second- and third-man's turn to rape me, I felt nothing; it was as if they were doing it to a corpse."*, she no longer knew who she was or where she was. Interviewing Mrs. Dawa, the memories of the traumatic experience reactivated pain and suffering, making it hard for her to cope with emotional distress: *"Thinking about it drives me crazy."* Mrs. Dawa added that she tries to avoid anything that might remind her of the event at all costs.

Affect dysregulation and self-blame

At the end of her story, Mrs. Dawa tells the consequences of the rape, because she was always afraid that her husband and the people would find out what had happened to her, which, in fact, did happen, causing her husband's estrangement. Feelings of guilt were also mentioned: *"If I hadn't gone into the woods to get something to feed my children and hadn't spent the night there, I wouldn't have gone through the incident. I should have stayed at home and starved to death instead of being raped"*, Mrs. Dawa said while crying deeply.

Health, PTSD and CPTSD symptoms

Mrs. Dawa reports that she had no physical illnesses before being sexually assaulted and was not taking any medications. He currently suffers from physical problems, especially eating: *"After the event, I lost my appetite, even though it's hard for me to find food."* In addition, Mrs. Dawa experiences anxiety related to poverty, and especially to mistreatment that her husband inflicted on her after he discovered "the things" before leaving home. She is afraid for the future and an imminent danger, especially the stigma: *"Women see me as one of them because they don't know what really happened. When they find out, I will be finished; maybe they'll put a rope around my neck,"* Mrs. Dawa explained, then she added: *"I am very afraid that what happened to me will be known by the people around me."* This hypervigilance, together with intrusive memories, negatively impact her daily functioning: *"I have difficulty doing the tasks I used to do properly"* and *"I keep reliving the same scene, I feel like I'm being raped at every moment of my existence."*

Family relationships have deteriorated due to the lack of family support. Since she got married illegally, she has never been at peace. She is the only one who takes care of her children, but she says

she was raped because no one helped her provide for her children. Her unfavorable environment and financial difficulties make Mrs. Dawa even more vulnerable, exacerbating insecurity and distress. Mrs. Dawa has difficulty falling asleep at night, very often she has nightmares in which she relives the scenes of the rape: *"At night, I can't sleep. But when I do manage to sleep, I only see nightmares, I still dream of the rape, and when I wake up, I am scared, it feels real, and I can't fall back asleep."* Sometimes she would jump out of bed when she realized her husband was next to her and scream, believing she was being attacked by a rapist. Due to this behavior in bed, her husband became suspicious: one day, in an attempt to answer her husband, she hesitated and from that day on the marital relationship became even worse, until he abandoned her.

Terror under the gaze of everyone (Narrative 3)

Chaline is a 19-year-old student, single, and the fourth of ten siblings. She lived with her uncle after losing both her father and mother.

Circumstances of the sexual assault

Three months before [the interview], Chaline was raped in the presence of her uncle, aunt, five cousins, and two younger sisters. They were all asleep in the house when armed bandits broke in. Some of the bandits had machetes and knives, while others carried firearms. They began threatening everyone present, and then two of them broke into the house. Her uncle was stabbed to death when he tried to protect her from the bandits. *"You can't imagine what they did to us. It was terrifying. Before they even started, just seeing them in the house was scary for us. I felt dead even before they assaulted me sexually."* It was really distressing and frightening: *"I felt an intense fear; it was like I was about to die."* Chaline reported with terror, *"I saw death in front of my eyes."*

Chaline feels ashamed and helpless because the despicable act committed against her happened in full view of everyone: *"What torments me the most is that they did this act in front of everyone in the house and no one was able to help me, despite my screams."* Chaline feels ashamed of all her relatives, as they all know about her misfortune.

Health

Chaline says that she had not experienced any health problems comparable to her recent situation. She was deeply affected by the death of her parents, particularly her mother, who passed away a few years after her father. The recent violence triggered suffering from death of her parents: *"Since I was raped, I have been more disturbed by the old traumatic memories than by those of the sexual assault."*

3.3. Disturbed interpersonal relationships

"Since I was raped in front of everyone, some cousins and siblings even insult me in front of visitors."

As a result, Chaline is suspicious of her family, she feels ashamed to approach them, and is

uncomfortable living with them as she did before: *"This act has disturbed our relationship because I tend to want to live alone, away from them."*

Previous social relationships have also deteriorated. She no longer wants to hang out with her friends, believing that they or their friends came to her house to commit these unbearable acts (death threats, rape and looting of valuables). *"I think they come to spy and then go back to commit crimes at night, and that my attackers might be among them."* She no longer trusts people. This attitude towards those around her has a negative impact on her student life. She finds it difficult to work with others, often isolating herself even in the classroom.

Symptoms of PTSD

Charline currently reports sleep disturbances caused by flashbacks and terrifying dreams in which she sees the men who raped her: *"I always dream of being threatened and raped; for this reason, I can't sleep."* She adds that she wakes up with a start, she is always afraid of being overwhelmed by sleep and would like to avoid these types of dreams: *"Besides the dreams, my sleep is disturbed by thoughts, images, and conversations about the event."* Furthermore, when she hears noises from the neighborhood at night, experiences intense fear (her heart beats fast), and diarrhea. To protect herself, she prefers to stay in her room alone, listening to music on her phone with headphones. She is always careful and vigilant not to be surprised by anything that might remind her of the scene, as memory makes her vulnerable. After four months, sexual violence has had devastating consequences on Charline's life, including social isolation, anxiety, physical symptoms, nightmares, hypervigilance, poor concentration, and helplessness.

Struggling to survive (Narrative 4)

Baraka (42 y.o.) is alone (no brothers or sisters) and has never known her parents (her mother died shortly after giving birth to her). She grew up with her grandparents; she has 7 children and lives in a terrible and worrying poverty.

Mrs. Baraka's appearance is unkempt (her clothes were very dirty, and her hair was unkempt) and her speech is very disorganized. At the beginning of the interview, she remains silent: *"What I went through is not something you can tell just anyone."* Only after trusting the interviewer – who had assured her of confidentiality and relief if she revealed her true problem without reservations – did she begin to tell her story.

Mrs. Baraka said that she had never experienced the joy of life, including the opportunity to go to school and receive a proper education like other children, as her grandparents were very poor and could not meet all her needs. At around 19 y.o., she married a man illegally, believing that this would alleviate her suffering. However, she was surprised by the man's disturbing behaviors such as daily

beatings, dishonorable insults, not helping the family, selling household assets to buy alcohol, and more. Due to her husband's behaviors and the lack of social assistance, her children were destined to develop Kwashiorkor and other malnutrition-related diseases. *"My worries intensified from the day I got married. I don't know how to cope, because I have no relatives, brothers, or friends to help me."*

Circumstances of the rape

As life worsened, Mrs. Baraka had to find a way to feed her children, venturing into the bush to gather firewood despite the dangers. Once, while she was in the bush, *"two bandits tied me up before doing their dirty work; they slapped me, spat on me, tortured me, and did everything to me. They took turns raping me, rested, and then came back to continue. This traumatic scene lasted for several hours. It was really bad."* She continues, *"I felt intense fear, not only for the act I was undergoing but especially for the weapons [guns, knives, machetes, etc.] with which they were threatening me."*

Physical and mental health

Mrs. Baraka's health has always been critical since she was very young. *"When I remembered that I had no one to help me, I had difficulty breathing, my heart was pounding, my stomach hurt a lot, and I felt diarrhea."* Her condition worsened with the sudden death of all members of her extended family (her uncle with his wife and her two children) three weeks after the rape: poison had been put in their food. This loss was very distressing for her, as her uncle was the only person who occasionally helped her: he gave her advice, took care of her children when they were sick, and scolded her husband.

What worried Mrs. Baraka was the lack of security and help after her uncle's death. She has no desire to live anymore: *"I lost the sense of life from the day I was raped and the day my uncle died."* Due to this suffering, her physical health has deteriorated significantly, and she has aged prematurely: *"You can see how much weight I've lost; it's only because of the hard-ships I've gone through and continue to go through."*

Marriage and social life

Mrs. Baraka reports that she has never gotten along with her husband, whom she considers the main cause of her serious problems: *"My husband was the first to know what I went through in the savannah. Instead of keeping it a secret, he spread the news. He tarnished my reputation in front of the people around me. Since then, those around me pointed fingers at me."* She is self-isolating to stay away from anyone she suspects is speaking badly of her. She avoids frequent places where large numbers of people gather, which has a negative impact on her daily activities. The husband even rejected her on the pretext that he could not continue to live with a raped woman who might be infected with HIV.

PTSD symptoms

These traumatic life events – poverty, intimate partner maltreatment, violent death of loved ones, rape stigma – have deeply wounded her. She continues to be disturbed both when she is awake (through thoughts and images that recall the traumatic memory) and through terrifying dreams: "*When these thoughts and images invade me at night, I cannot sleep until morning. And if I manage to get some sleep, I often dream about the event I experienced in the bush.*" Reliving these past events, she feels her wounds and her life is totally devastated.

She avoids frequenting crowded places, especially if she suspects that those who were mocking her are there. She has developed negative ideas about the people around her. Furthermore, she becomes hypervigilant (her psyche always prepares to face an imminent danger), poorly concentrated and often scared.

Lack of life meaning

Since she was raped, she has developed a feeling of hatred towards the world and mistrust about the people around her: "*The world is evil.*" She judges all men negatively: "*I don't want to live with another husband; men are all the same. They are no different from those who raped me or my husband, who mistreated and abandoned me for a long time.*" Mrs. Baraka is afraid of the future. Depression and loss of hope for life led her to a suicide attempt.

Discussion

This study provided a report of narratives collected among Congolese refugee women who have suffered sexual violence. Although the number of interviews is small, these narratives are interesting from an existential, as well as clinical point of view, particularly considering the circumstances in which the interviews were conducted. Shame, interiorized stigma and cultural beliefs generally push victims to keep these experiences hidden ("What I went through is not something you can tell just anyone", Baraka), so it is difficult for them to confide their drama even to other women ("When they find out, I will be finished; maybe they'll put a rope around my neck", Dawa). Cultural expectations and norms (script), in several regions of Sub-Saharan Africa (Bovey et al., 2024), do not encourage emotional expression, so that uncontrolled anger or crying is interpreted as a script violation and inappropriate (e.g., it disrupts community harmony). Consequently, suppression or masking emotions became adaptive strategies for emotion regulation (Heim et al., 2022; Patel & Hall, 2021).

All women reported the core symptoms of PTSD, although with varying manifestations. First, intrusive memories, sleep disorders, and nightmares are referred ("I am scared, it feels real, and I can't fall back asleep", Dawa) as commonly associated with PTSD (Hsu et al., 2018; So et al., 2023). In a case (Chekanabo), rape triggered the memories of previous traumas (looting, violent death of loved ones) by terrifying thoughts and dreams ("I dream of being killed, of being chased by armed

men, of being tortured and raped”), accentuating woman’s helplessness (“the incident made me more vulnerable”). Second, a persistent perception of threat pervades the existence of the victims, because they fear that the violence may recur in the future, generating anxiety and hyperactivation (e.g., suspecting the presence of the aggressors among people, fear of being spied on, hearing suspicious noises at night). Finally, avoidance (Wyatt et al., 2017) is a common strategy, with negative consequences on daily functioning and social withdrawal, including schooling and peer relationships (as for the young Cheline, closed in her room with music in her headphones).

In addition, alterations of thought (e.g., “Thinking about [the rape] drives me crazy”, Dawa), somatizations (e.g., stomach pain, diarrhea, trouble breathing, palpitations) and eating problems (“I lost my appetite, even though it's hard for me to find food”, Dawa; “You can see how much weight I've lost”, Baraka) are referred. Although the interviews did not have a diagnostic purpose, referred problems can be linked to disturbances (e.g., impairments in cognition, anxiety, or eating disorders) often associated with PTSD and sexual trauma (Bryant-Davis et al., 2010; Wonderlich et al., 2001). According to the components of DSO (WHO, 2019), the irreparable loss of identity, value of life and hopelessness are striking in the women's narratives. Constant sadness and anger (towards the aggressors, the husband, or the community that refused them) are experienced by victims of sexual violence, but women even self-blame (“If I hadn’t gone into the woods to get something to feed my children [...] I should have stayed at home and starved to death instead of being raped”, Dawa). The loss of personal value (as a woman or wife) is another significant core of experiences, since women report feeling humiliated by others or disgusted with themselves (i.e., feeling dirty). These negative feelings are also shaped by cultural scripts embedded into African groups (Bouzidi, 2018; Bovey et al., 2024; Heim et al., 2022; Mukwege, 2021; Patel & Hall, 2021), such as the (dis)value of women, her submission to the family, the coercion as normative, the forced marriage and the virginity value, the religion, the beliefs and superstition. On one side in many African countries, including DRC, socio-cultural norms generally see woman as submissive and willing to accommodate men's sexual needs, until justify sexual violence even against girls (Mukwege, 2021; Verelst et al., 2014). On the other hand, rape is a dishonor for the family and the community, so the woman is accused (e.g., she is infected with HIV) or repudiated (“My husband was the first to know what I went through in the savannah [...] he spread the news. He tarnished my reputation in front of the people around me. Since then, those around me pointed fingers at me”, Baraka). Rape stigma (Jewkes et al., 2022) has devastating consequences: sexual assault humiliates the woman (internal stigma), who devalues herself and feels despised (or irremediably damaged: “I am no longer like other women”, Chekanabo). It also distances her from the family and the community (external stigma) – “some cousins and siblings even insult me in front of visitors” and “I tend to want to live alone, away from them”

(Cheline) – increasing insecurity and gender-based inequalities. Literature on CPTSD describes a vicious circle involving traumatized women: the sexual assault leads to “(1) the fear of judgment or stigma if the trauma is disclosed, (2) a feeling of shame to the violation of cultural scripts, (3) subsequent social withdrawal, (4) and a lack of support and potential reproach from the community (5), which can further exacerbate the symptoms” (Bovey et al., 2024, p. 19). In addition, poor family support and rape stigma (Nöthling et al., 2022; Verelst et al., 2014), together with the absence of adequate health services (Wyatt et al., 2017), are associated with increase of suffering and PTSD symptoms. DSO includes despair and altered meaning systems that emerge dramatically in the women's narratives: “I can no longer trust anyone, the world is evil and dangerous” (Chekanabo); also, “men are all the same. They are no different from those who raped me or my husband, who mistreated and abandoned [...]”, “I lost the sense of life” (Baraka).

Mukwege (2021) reports that sexually abused victims refer that they no longer feel any emotion or desire, because their life has lost meaning. Women lose interest in usual occupations (including school and job, perpetuating gender-inequalities) with extreme health consequences, including depression and suicide (Bryant-Davis et al, 2010; Lambert et al., 2024; Ndungu et al., 2020). Other studies report sexual slavery, transmitted infections, unwanted pregnancies, abortion, promiscuous sexual practices, and substance abuse in victims of sexual trauma (Kuupiel et al., 2024).

Age, Honorine, Rache and Mazawo (fictional names) are other young women met during the interview period. They were kidnapped in the forest and used as sex slaves for months. After escaping, due fear and shame of being humiliated, they abandoned the village. Currently, they live almost on the street prostituting themselves; they do not need money for living, but to find drugs, because to keep the events of the past under their control they must always be under the influence of drugs.

In conclusion, the study offers a qualitative contribution to the clinical evidence on the traumatic consequences of sexual trauma (Mhlongo et al., 2018; Muluneh et al., 2020; Tadesse et al., 2024; Wyatt et al., 2017) among internally displaced women in RDC. The study adopted an emic approach (Heim et al., 2022; Patel & Hall, 2021) with the aim of bringing out, from the women's words, the complex intertwining among contextual factors (mainly, extreme poverty and insecurity, perduring war and gender-based violence), life stories (i.e., multiple adversities) and cultural meanings (scripts) of suffering they express. Common emerging themes are the violated identity, the loss of life meanings and hope as core characteristics of a CPTSD.

However, the study is not exempt from some limitations. First, the study is based on four semi-structured interview that were conducted in the local language to be accessible to women who were illiterate or had a low instruction. Therefore, it cannot be excluded that in translating the local language terms into English some nuances or cultural meanings of the terms were lost, even though

the interviewer – who is one of the authors – was a native Congolese. Secondly, the context in which the interviews were conducted was particularly difficult for the refugees: overcrowding, extreme poverty, and fear of armed attacks characterized the Bulengo Camp, as well as other refugee camps on the outskirts of Goma. Furthermore, the interviewer was a man, which might have prevented the women from sharing their horrific experiences. However, the interviewer was a priest with clinical training and empathetic listening skills (see James et al., 2014; Lonsway, & Archambault, 2023), so he was able to reassure the participants and put them at ease before they shared their painful stories. Finally, it is possible that verbalizing the sexual violence reactivated painful emotions making the memories incoherent, fragmented, or incomplete (Forest & Blanchette, 2018), thus limiting the data collection, despite the interviewer's effort to follow the flow of the narratives, together with the nonverbal expressions of suffering (such as silences or inconsolable crying) of the interviewees.

Conclusion

Sexual trauma among refugee women is a humanitarian emergency, that calls for Governments' policies and international efforts to ensure protection for the victims and prevent the consequences of gender-based violence. Particularly, studies suggest focusing on factors that can improve woman's mental health, such as social support, living with a partner, cultural identity, sense of connection to community, and access to primary health services (Chiumento et al., 2020; Kuo et al., 2021; Lambert et al., 2024). Some brief interventions have received preliminary efficacy evidence for the treatment of PTSD in low resource settings in Africa (Booyesen & Kagee, 2021), but further research is needed. In fact, other studies recommend targeted interventions, but not early counselling, to prevent the long-term consequences of PTSD among the victims of sexual assault (Mhlongo et al., 2023). In addition, studies evidence that illiteracy and extreme poverty are key risk factors for depression and poor health (Ndungu et al., 2020), therefore it's important that programs for refugees integrate the promotion of basic services (e.g., food, instruction, job skills, etc.) with psychological interventions.

A culturally sensitive (emic) approach draws attention to barriers that may limit access to health services among sexually traumatized women. Normalization of violence, rape stigma, cultural scripts, emotions suppression are some of the factors that limit access to health services, and do not motivate women to seek help (Bovey et al., 2024; Muluneh et al., 2020). Unfortunately, in Sub-Saharan regions the availability of mental health professionals is scarce, particularly the psychologist is not well known in the Congolese communities (Otita Likongo et al., 2022). This suggests the need to make available, even within the precarious and overcrowded conditions of refugee camps, more professional resources and protected places where women can receive initial help. Finally, more effort is required to prepare and educate professionals (not only health workers, but also social workers or

volunteers) to cope with trauma-related stress, to build an empathetic approach with traumatized women and to facilitate their access to mental health interventions.

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Declaration of Interest

The authors declare no conflicts of interest.

Authors' contribution

L.B., J.P.O. and M.I. assisted with concept and study design; J.P.O. and M.O.L. assisted with resources and investigation; J.P.O. assisted with interview analysis and the generation of the initial draft of the manuscript; L.B. and J.P.O. assisted with data interpretation; L.B., M.O.L. and M.I. assisted with manuscript editing and supervision. All authors contributed to and have approved the final manuscript.

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