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Stress management in support of victims of rape and sexual assaults in post-conflict context: the case of medical and psychosocial stakeholders in Burundi

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Abstract — **This paper presents the main results of a case study conducted with medical and psychosocial stakeholders in Burundi. In a context of post-conflict, these people support victims of rape or other sexual assaults. Given the great distress and suffering of users, we tried to better understand how they proceed to manage the stress of their profession and enduring investment in such a psychologically difficult professional field. Three instruments were used to collect data: the *Coping Inventory for stressful situations* provided us information about the strategies implemented by stakeholders to preserve their mental and professional balance; the *Revised personal style inventory* allowed us to better understand their interpersonal relationships and to assess their vulnerability to depression; the motivations of the 13 Burundian participants and their intervention practices were discussed during semi-directive interviews. Results show that internal resources, peers' support, collaboration with partner organizations and general social support seem to be components of types of operation that can help them manage these stressful situations.**

Burundi; sexual assaults; stakeholder support; stress management; enduring investment

I. INTRODUCTION

In October 1993, a unit of predominantly Tutsi Burundian army arrests President Ndadaye, a democratically elected Hutu, and some of his collaborators. He is assassinated the same day, just three months after his election. The chaotic period that follows degenerates into a civil war with very strong ethnic overtones. Interethnic conflicts cause tens of thousands of Hutu and Tutsi deaths. Thanks to international mediation, peace accords are signed in 2000 and a transition process (consisting of alternating leadership between Hutu and Tutsi peoples), over a period of 36 months, is set up to organize democratic elections.

The country has many widowers, widows and orphans. As a result of these conflicts, women and girls have suffered, and continue to suffer, sexual assaults. Today, in post-conflict context, Burundi must cope with severe trauma of the population. The authorities had never faced such a situation and a large-scale management of trauma (war wounded, rape victims, psychological disorders) is a major challenge for the medical and psychosocial stakeholders of the country.

II. TARGET POPULATION, OBJECTIVES AND RESEARCH QUESTIONS

Our case study took place in a post-conflict context with people who are living, during their work to support victims of sexual abuse, in psychologically very challenging conditions. These professionals have in front of them people in great distress, both physically and psychologically traumatized. They bear the brunt of the painful effects of their stories. Persons exercising a profession for help and support are indeed affected by the suffering of users. Between the desire for omnipotence and the confrontation with helplessness, the stakeholder finds himself drawn into a "*violent relationship in which the patient puts him*" [1].

To lead a study on the population of Burundian medical and psychosocial stakeholders that support victims of rape and other sexual assaults seems us interesting insofar the quality of their work has a direct impact on the chances of victims' rebuild. So we tried to better understand their experiences, their profile and their working conditions for intervention in the field of sexual assaults. How do stakeholders manage to take on and overcome the emotional weight of their experience and continue their work? Where do they draw the strength to contain the suffering of others?

III. METHODOLOGY, INSTRUMENTATION AND INVESTIGATED CONCEPTS

We used three instruments to collect data that could answer our research questions: the Coping Inventory for stressful situations - CISS developed by Endler, Parker and James [2], the Revised personal style inventory - RPSI developed by Robins, Ladd, Welkowitz, Blaney, Diaz and Kutcher [3], and semi-directive interviews.

The CISS is an instrument of self-assessment strategies used by people confronted with stressful situations. "*Coping strategies refer to the specific efforts, both behavioral and psychological, that employ people to master, tolerate, reduce, or minimize stressful events*" [4]. It is based on three main dimensions: task (the participant seeks a solution to the problem by action), emotion (it is quickly overwhelmed, missing distance, and gives emotional responses) and avoidance (it tries to reduce the stress either by distraction or social diversion, which are two subscales of the inventory). This questionnaire includes 48 items (16 items for the dimension of the task, 16 for emotion, and 16 for avoidance).

In the French version, Rolland added a professional set, allowing to refine the study of the particular case of stakeholders [2]. The CISS provides us guidance on the strategies implemented by stakeholders to preserve both their own mental balance and professional balance. This tool gave us the possibility to identify common patterns of coping strategies in the sample.

The RPSI examines the psychological functioning of the participant in his interpersonal relationships and assesses the vulnerability to depression, through the dimensions of sociotropy and autonomy. "*The sociotropy is a component of social skills that can be characterized by a state of social dependence that is manifested by the expectation of support from others*" [5]. Conversely, the autonomous participant attaches great importance to the achievement of its objectives and self-development without being under control or coercion of others. Sociotropy or autonomy can dominate the psychological functioning of a person but they should not be regarded as personality types; they may have a similar intensity. The questionnaire includes 48 items. Sociotropy dimension has three subscales: "*concern for what others think*" (7 items), "*dependence*" (7 items), and "*the desire to please others*" (10 items). The autonomous dimension also has three subscales: "*perfectionism and self-criticism*" (4 items, unrated), "*the need for control*" (8 items), and "*defensive separation*" (12 items). This instrument seems us interesting insofar it can give us more information on stakeholders' profiles: are they independent or dependent on the approval of the others to feel fulfilled? Their approach in the victims support will be influenced by this feature.

Semi-directive interviews gave us opportunity to identify elements of the stakeholder's experience and its perception of its work. The advantage of this type of interview lies in the respect of the interpersonal dimension of communication [6]. According to Walker, it can "*encourage the informant to tell, in its own words, experiences and attitudes related to the research problem*" [6]. During these interviews, we collected anamnesis information (age, marital status, sex, profession,...), information about the course and the motivations of the stakeholders (studies, training and professional experiences, personal motivations,...) and their intervention practices (working conditions, type of aided people, emotional experience, stress management, received support,...).

By opting for an open questions interview, we wanted to give the participant the opportunity to express themselves freely on topics that we have chosen for two reasons: their ability to provide relevant clues on the stakeholders' experiences and the possibility to cross them with the inventories results. Indeed, we have attempted to link these elements with the results of the CISS and the RPSI in order to highlight any common characteristic of the sample.

IV. SAMPLE CHARACTERISTICS

Our sample includes 13 Burundian participants aged 28 to 48 years (mean: 37.53 years, standard deviation: 6.31). They work in one of the following centers: *Association Nturengaho* (Bujumbura), *Centre MSF/SERUKA* (Bujumbura), *Association pour la défense des droits de la femme* (Bujumbura), *Maison Shalom* (Ruyigi), *Association Swaa Burundi* (Society for Women against Aids in Africa, nine centers based in seven provinces).

Ten subjects were married, one is a widow, one is single. Only one man includes our sample (the centers to which we addressed mainly employ women). Regarding educational level, six participants possess a technical secondary education degree, five have a university level and two are medical doctors (Table 1).

TABLE I. SAMPLE CHARACTERISTICS

Stakeholders	**Sex**	**Age**	**Martial status**	**Children**	**Field training**	**Curent occupation**	**Seniority**
1	F	28	Single	0	Social school	Social worker	5 years
2	F	28	Married	2	Social school	Social worker	2 years
3	F	37	Divorced	1	Technical secondary education	Social worker (support)	2 years
4	M	36	Married	2	Clinical and social psychology	Psychologist	8 years
5	F	36	Married	2	General medicine	Doctor	4 years
6	F	37	Married	4	Educational sciences	Support psychologist	5 years
7	F	47	Married	3	Nursing school	Nurse	2 years
8	F	48	Widow	4	Social school	Social worker	2 years
9	F	33	Married	1	General medicine	Doctor	2 years
10	F	37	Married	4	Clinical and social psychology	Psychologist	6 years
11	F	42	Married	5	Educational sciences	Psychosocial assistant	5 years
12	F	35	Married	2	Clinical psychology	Psychologist	7 years
13	F	44	Married	4	Nursing school	Nurse	6 years

V. MAIN RESULTS

We only present global trends for the entire sample and for each class of stakeholders (according to their occupation). These trends were identified during the cross-sectional analysis in which we have articulated participants' declarations and their results in the two inventories. The results of individual analyses can't be presented here.

A. Global trends

Seven stakeholders have the highest score in the dimension "task" of the CISS (S3, S4, S6, S7, S10, S11, S12). Four relieved their stress preferably through social resources (S1, S2, S5, S13). One participant's profile is dominated by emotion (S8) and the last one uses avoidance (S9). According to Table II, it can be argued that the general trend leans toward action to solve problems and relieve stress.

Profile at RPSI is more varied. Five stakeholders present their highest score in the sociotropy subscale "*to please others*" (S1, S3, S4, S10, S12), four others in the autonomy subscale "*need for control*" (S2, S6, S7, S9), one in the autonomy dimension "*defensive separation*" (S13), two in the sociotropy dimension "*concern about what others think*" (S5, S8) and the last one in the sociotropy dimension "*dependence*" (S11). Sociotropy trend seems most representative of personal style in our sample (eight stakeholders out of thirteen).

During the interviews, all stakeholders admit indeed to find comfort in occasional and non-formal staff meetings or exchanges of experiences and advice. The use of family support was abandoned because the stress of work contributed to destabilize conjugal balance. Unanimously, the participants enjoy relaxation sessions. Distraction as a moderator of stress becomes important in friendly interactions or group activities. One stakeholder only says relaxing herself with prayer.

Social mediation appears to play a major supporting role in the development of affects. The interviews and the CISS results indicate in fact a massive use of social and professional resources (eleven out of thirteen). To feel supported, all stakeholders assert to rely on team capabilities to manage psychologically stressful situations. Furthermore, the notes to the CISS subscale "*social diversion*" are well above the average for all sample members.

About motivation, it appears that only four participants have really chosen the profession of assistance they exercise (three psychologists and a social worker). Both doctors have followed the paternal career. The seven others are working in the field of victim assistance by Ministerial designation. Now they say they enjoy their work despite the difficulties it entails. These stories seem to be consistent with the results to RPSI, as the sociotropy trend mainly characterized the sample.

Globally, we encountered some reluctance by stakeholders to talk about their own emotions. However, the feeling of pain was expressed by eight of them. Fear of aggression (for their daughters and themselves) is mentioned by five participants and seems to be omnipresent; according to three participants, the victims' stories maintain these feelings. Six expressed anger, three others their feeling of anxiety. But ultimately, everything happens as if their suffering was dwarfed by the everyday distress around them, as if their support mission required them to ignore their emotions.

They are outraged by community reactions and the impunity enjoyed by assaulters. Anger is even more intense when they are confronted with cases of incest or rape of very young children. This feeling is difficult to overcome for some female stakeholders and may cause conflicts in relationships with their husbands and other male family members. More generally, the encounter with the suffering of children abused by adults tends to affect the stakeholders' capacity to manage their stress.

Only two participants (a doctor and a psychologist) put their powerlessness into words. This feeling, slightly less pronounced among others, might be delayed by the rewarding effect of small daily successes such as the opportunity to help a victim become independent again, successful family mediation, the re-schooling of teenage mothers, etc. Eleven out of thirteen stakeholders managed to feel satisfied with their work even if the cultural, legal and material barriers are causes of frustration.

TABLE II. MAIN RESULTS AT CISS ANS RPSI FOR ALL SAMPLE

		S1	***S2***	***S3***	***S4***	***S5***	***S6***	***S7***	***S8***	***S9***	***S10***	***S11***	***S12***	***S13***
CISS	Task	35	28	**57**	**68**	20	**52**	**54**	44	43	**67**	**68**	**57**	58
	Emotion	35	38	31	36	57	43	45	**50**	43	48	46	38	51
	Avoidance	46	43	42	58	57	46	34	36	**52**	42	42	37	44
	Distraction	39	45	39	55	54	47	39	36	51	36	39	36	36
	Social diversion	**59**	**50**	48	58	**63**	48	36	40	50	55	48	40	**61**
RPSI	Concern for what others think	48	58	37	42	**70**	49	48	60	32	44	55	55	53
	Dependence	51	51	60	32	67	45	43	52	39	39	**62**	52	56
	The desire to please others	**58**	38	**67**	**50**	43	46	43	50	34	**50**	46	**68**	55
	The need for control	51	**61**	49	31	59	**61**	**61**	49	**45**	31	49	47	55
	Defensive separation	52	52	48	28	55	53	53	52	35	45	53	52	**71**

B. Trends by professional class

1) Social workers (S1, S2, S3 and S8): Social workers' profiles at the CISS diverge: one prefers avoidance, another social diversion (which is a subscale of avoidance), the third adopts the task-oriented strategies and the fourth combines emotion and task. However, all four share a common characteristic: their score at social diversion subscale is higher than distraction subscale.

Overall, all social workers present a sociotropy-oriented personal style at the RPSI. The differences appear at the subscales: S1 and S3 get a higher score on the subscale "*pleasing others*" while S8 attaches greater importance to "*what others think*". The best score of S2 is reached at autonomy subscale "*need for control*".

2) Nurses (S7 and S13): Both of the nurses have the same general profile (task > emotion > avoidance). The search for solutions to stressful situations leads their actions while avoiding reactions are less common. On avoidance, they are different: S7 seek to relieve stress through distracting activities while S13 finds more comfort in her social relations.

Overall, S7 and S13 have a balanced personal style with a slight advantage for sociotropy. But when we enter into the details of the subscales, we find that the dimensions that best characterize their personal styles are autonomous ones. In the case of S7, the "*need for control*" mainly leads her attitudes in relationships with others; S13 has a preference for the "*defensive separation*".

Both nurses' operation seemed very close. Is this due to their profession, which requires the ability to make decisions quickly in medical emergencies? Does their long experience (20 years) influence their personal style?

3) Doctors (S5 and S9): Both doctors favor avoidance strategies. On the other side, results at avoidance subscales show a very slightly different way to handle stress: S5 prefers social diversion while S9 scores are quite similar. S5 works with more avoidance and emotion while S9 faces stressful situations by using the three strategies in a more or less balanced way. However, avoidance is their preferred mode.

S5's overall personal style tends towards sociotropy when S9's one seems balanced. Sociotropy dimension "*concern of what others think*" is predominant for S5 while S9 grants it less importance. Doctors' profiles present "*dependence*" dimension in second place.

4) Psychologists (S4, S6, S10, S11 and S12): Of the four categories of stakeholders, psychologists have the most homogeneous profile. Indeed, they exhibit common characteristics, despite the difference in age and sex. The overall pattern of coping is task-oriented for the five participants and the second most important dimension is the social diversion. Social support is their preferred mediation.

Regarding to personal style, four psychologists (S4, S10, S11, S12) have a high score in a sociotropy subscale. "*To please others*" dimension is preferred by three of them, while the fourth opted for the "*dependence*". Similarly, the "*concern of what others think*" dimension appears in second place for three of five psychologists. We can therefore say that these results indicate a strong orientation among psychologists towards the sociotropy dimension.

Finally, emotional responses do not seem frequent. Is this a salutary distancing to prevent collapse facing such suffering? Psychologists are called "*abaremesha mutima*" in Burundi, literally "*those who calm the heart, those reassuring*". Would this role explain the reluctance to express their feelings and ill-being and the emphasis on what patients expect of them? Maybe do they respond to a "*need of social desirability*" [2]?

C. The absence of traditional practices

Through participants' interviews, we hoped to identify some terms of a "traditional" support of sexual assaults victims. It appears that this type of aggression remains a taboo and that traditional authorities have planned sanctions which are supposed to protect family honor to the prejudice of the victim. The real disgrace for an African family, according to one stakeholder, "*is the risk not to marry its daughter*". The community's response, which is either a penalty applied to the aggressor or a marriage organized between him and the victim, has been established for the sole purpose of avoiding the humiliation of the parents. The individual dimension is denied.

But given the magnitude of the phenomenon, the "cultural patch" is often inapplicable. This is the case of rape perpetrated by soldiers, the gang rape, numerous cases of incest or rapes by domestic workers in young children. Moreover, some cultural beliefs and prejudices about rape are denounced by most participants: they make the prosecution of sex offenders impossible, which denies the very existence of the crime of rape. Furthermore, a centre coordinator explains that there is no term in Kirundi, the language of Burundi, to describe this act: "*the words we use are borrowed words or just recently made*".

These cultural constraints could provide a partly explanation of the difficulties in prosecuting rapists because they help to maintain the silence. In this context, stakeholders have no option but to go against the traditional code, which is traumatic for the victim, and turn to Western practices of individual care.

VI. Conclusions and Discussion

The aim of this research was to understand what helped stakeholders to withstand the stress of their profession and the suffering of victims of rape or other sexual assaults they support. We attempted to determine a profile that could explain an enduring professional investment in such a psychologically difficult area.

The comparison between results of the inventories and the data from individual interviews allowed us to identify types of operation that can help them manage these stressful situations. It seems undeniable that in addition to internal resources, social factors such as peers' support, collaboration with partner organizations and general social support

contribute to maintain their professional and emotional balance.

The sociotropy trend is found to varying degrees across the sample. Faced with stressful situations, most participants use task-oriented coping strategies. The use of social and professional support is for all of them the favorite way to manage their affects. Finally, the combination of individual coaching of the victim and family mediation for the purpose of a successful social reintegration seems to suit all stakeholders.

The commitment to restore a positive self-image to the victims and help rebuild their self-esteem related to our participants secondary benefits in terms of "*moral retribution*" which are motivation boosters able to update their capacity for empathy. In this connection, we can only agree with Dejours when he states that "*users*' *recognition allows to those who work to transform his suffering into identity improvement*" [7].

Thus, the association between social and professional support, the tendency to focus on finding solutions and sociotropy style could explain their enduring involvement. Support from colleagues is essential to prevent burnout of caregivers [8].

We would like to conclude by recalling that our work can not claim to be exhaustive, as we have addressed only one dimension of the problem. It would be interesting to study the medium and long term impact of the phenomenon of sexual assaults on medical and psychosocial staff. Also, the question of the role of the church in victims' support and in their social bonds strengthening deserves to be deepened. Development of children born of rape is a major challenge. Burundian society is patrilineal. What structure should be established for these children, called "*time bomb*" by a legal representative of a Burundian NGO, to reinstate them with dignity in the community?

Regarding stakeholders, we met only a few people for a short period. It would be interesting to realize a further study with a larger sample for each category of stakeholders. It seems already possible, however, to make some recommendations. Most stakeholders request more training and seminars that would be for them the opportunity to become aware of the difficulties of their peers and to learn from the practices that have worked in other similar situations. Given the enormous emotional weight of their work, it would be appropriate to increase the supervision sessions to work the expression of emotions. An increase in the number of stakeholders could be a significant initiative that would reduce the trauma exposure of each of them. Obviously, that requires material means that the centers do not yet have.

The impunity severely compromises the work of medical and psychosocial support because, according to stakeholders, victims can only be rebuilt if their assailants are prosecuted and punished. Of course, this would require a prior change to the perception of the crime of sexual assault, "*a revolution in attitudes and representations*" [9].

Finally, although our sample is composed of Burundians in a local environment, we used inventories developed and tested on Western populations. The benchmarks are Western. Language problems did not arise: all participants of the sample speak and write French. The results may be tainted by cultural bias. We hope to have reduced this impact, both by triangulating tools and by combining levels of analysis. The prospect of creating valid tools to study this type of questions, adapted to a non-Western culture, seems us nevertheless very interesting and should be the subject of future works.

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