This paper presents findings from research about the psychological effects of rape among 15 Ghanaian and 15 Liberian rape survivors comparing them with 15 Ghanaian and 15 Liberian women not raped living in Ghana. We found that both Liberian and Ghanaian rape survivors had increased levels of depression and that both Ghanaian and Liberian women who had been raped by familiar perpetrators exhibited higher levels of depression than those raped by strangers. Liberian survivors exposed to limited cognitive behavioural counselling exhibited lower levels of depression despite being displaced and living in a refugee camp. Our findings on the psychological effects of rape and the mitigating effects of counselling are the first of their kind for Ghanaian and Liberian women. We hope that the dissemination of these results will encourage the provision of counselling for all women who find themselves victimized by rape.

Gender-based violence is a major issue on the international human rights agenda (UNFPA, 2012). It incorporates elements of traditional practices identified as harmful and degrading to women and varies from culture to culture. Social contracts between men and women within Ghanaian society have evolved in ways that demonstrate the...
controlling power of men at the detriment of women (Gender Studies, 1999 & 2010). In customary marriages throughout the country, a man pays a bridewealth for his bride: for some men this transaction transfers ownership of the woman to him as one might acquire property.

The United Nations (UN) definition of violence against women stems from the declaration on the elimination of violence against women that was adopted by the UN General Assembly in 1993, and to which Ghana and Liberia acceded (Appiah & Cusack, 1999). Gender-based violence is defined as “violence which jeopardizes fundamental rights, individual freedom and women’s physical integrity” (UN Declaration, 1993). The declaration also stipulates that gender-based violence encompasses physical, sexual, and psychological violence perpetrated or condoned by the state wherever it occurs.

According to the United Nations (2012), the sexual assault of women is a common feature of conflict (UN Report on Women, 2012), and rape (defined as non-consensual penetrative sex with a woman 16 or older29) is used as a form of social control during political upheaval. For example, during the brutal and dictatorial rule of Kutu Acheampong (1972-78; the Acheampong era) government soldiers used rape of female university students as a method to control student demonstrations on campus (Ahiadeke, 1997). Similarly, in El Salvador, Guatemala, and other Latin America countries with a long history of political and social conflict, women face the risk of rape and sexual violence daily; rape was a hidden dimension of the war in Guatemala for many years (Amnesty International, 2005). Liberian women were also raped by rival rebel soldiers during the Liberian civil conflicts (Norwegian Refugee Council, 2011; Diplomat, 2012).

This study focused on the correlation between rape and depression among Ghanaian and Liberian women residing in Ghana; Liberian women were raped during the Liberian civil conflict and residing in Ghanaian refugee camp. Depression in these women was compared with that in Ghanaian and Liberian women residing in Ghana who had not been raped. We hypothesized that the circumstance under which a rape occurred (e.g., used as an instrument against women during civil conflicts war or not) as well as whether or not women received subsequent counselling would affect levels of depression among survivors. Therefore, we analyzed 1) levels of depression among survivors (Ghanaian and Liberian), 2) relationships between depression level and knowledge of the perpetrator (close relative/familiar

29 The Ghanaian penal code differentiates between sexual assault against girls younger than 16 defilement and rape, which it defines as “the carnal knowledge of a female forcibly and against her will” of a woman 16 or older (both Ghanaian and Liberian penal codes). Here, we use the term ‘rape’ to refer to non-consensual penetrative sex of any female of any age.
perpetrator or stranger), and 3) how psychological counselling affected depression levels among survivors.

**Historical & Demographic Background**

The Liberian civil war began in 1989; at the time, Samuel Doe was the political leader but he was overthrown by Charles Taylor. Reportedly, nine separate military groups fought in the war, and 2.5 million people were forced to flee their homes. During the civil conflict, women and girls were subjected to specific forms of violence and abuse, including rape and defilement, regardless of whether they remained in their communities or were trying to escape to neighboring countries. Sexual violence is known to be a central problem in Liberia: pre- and post-war data indicate that rates of sexual assault on women range from 49–77% (Feminist Critics, 2009).

According to research conducted by Doctors without Borders (2011), 85% of the perpetrators of rape in Liberia knew their victims. For instance, boy soldiers were often forced to rape their own mothers, sisters, and grandmothers as part of their initiation (Norwegian Refugee Council, 2011). Reportedly, most women and girls were gang-raped by their male relatives, particularly by their sons (Feminist Critics, 2009). In an attempt to escape from the torturous experience of all forms of sexual assault during the war, women and girls fled to Ghana for refuge. In responding to the needs of these women and other refugees, in 1990 the government of Ghana established the Budumburam refugee camp to accommodate all Liberian refugees. The Budumburam camp is approximately 140 acres with ill-defined boundaries and lies in a semi-urban area about an hour’s drive from Accra. Many of the women in the camp had been raped, primarily as a weapon of war by perpetrators well known to them prior to moving to the Ghanaian refugee camp (Dick, 2002). In 2008, the UN Population Fund (UNFPA) and other institutions helped the Liberian government set up a special court on sexual violence. At the time, many survivors were still in Liberia; some spoke up and sought help, including psychological counselling (Diplomat & Canada International, 2012). Thus, some of the women currently living in the Budumburam camp received psychological counselling while still in Liberia (Omata, 2012).

Although awareness on sexual violence in Ghana is fairly high, barely a day passes without media publication on some form of sexual violence against women and girls (Gender Studies, 2010). Data reveal the prevalence of sexual violence in Ghana: 20% of women in Ghana report their first sexual experience as being forced, and 33% report fondling and touching against their will (Ardayfio-Schandorf, 2005; Ark Foundation, 2011; Kuenyehia, 1998). Among men in Ghana, 5% admit to having forced sex with their wives or girlfriends (Ardayfio-Schandorf, 2005).
The Domestic Violence Victims Support Unit (DOVVSU) of the Ghana Police Service reports that on average, 21% of Ghanaian women are forced by their husbands to have sex, 8% of all women have been raped, and 6% of all girls have been raped (of which 78% were defiled by a close relative, acquaintance, or authority figure; DOVVSU, 2010). More than 10,000 rape cases have been reported over the last decade in Ghana, and in 2012, DOVVSU handled a total of 1,164 reported rape cases in Accra alone. The Gender Studies and Human Rights Documentation Centre in Accra stresses that these numbers likely underestimate the reality: 7 of every 10 rape cases go unreported (Gender Studies, 2010). Only 17% of adult victims and 22% of adolescent victims report an assault to a member of their extended family, and only 34% of adults and 22% adolescents tell their friends (Gender Studies, 2010). As in Liberia (although not a wartime situation), data about reported cases of rape indicate that more than 90% involve perpetrators familiar to the women: step-fathers, uncles, and male neighbors (Gender Studies, 1999). While adolescent females are more likely to be forced to have sex by a non-relative male, adult women are more likely to be forced to have sex by a male relative (Cusack, & Manuh, 2010; Gender Studies, 1999).

The evidence indicates that rape in both Liberia and Ghana is a major social problem. Few data are available about gang rapes in either country, but rapes by close relatives and persons known to the victim are certainly common in both countries, and are more common than rapes by strangers. The frequency of unreported rapes points to a culture of secrecy and silence around rape: rape and defilement are associated with negative and stigmatized attributes such as promiscuity, unfaithfulness, and personal weakness (WHO, 2008). Rape affects the health and wellbeing of women, leading to increased levels of depression, distress, and trauma (UNFPA, 2011). Rape compromises the ability of women to cope with daily life (Kilpatrick, 2004), and women may experience anger, thoughts of revenge, and nightmares (Calhoun, 2008). Survivors are likely to experience fear and anxiety (Briere & Jordan, 2004; Calhoun, 2008). Cohen and Roth (1982) reported that rape victims are generally acutely distressed during the first few months. They can also develop chronic difficulties including nightmares, low self-esteem, fear, depression, shame and other psychological disorders (Burt & DeMello, 2002; Campbell, 2008; Campbell, Dworkin & Cabral, 2009; Finkelhor, 1994). Research conducted by Kilpatrick et al, (1984) and more recently by the Zimbabwean Women’s Network (2010) also suggests that almost one-third of all rape victims develop PTSD at some point during their lifetime, and more than 1 in 10 rape victims develop long-term PTSD.

Women may react to rape differently, depending on their personality, past experience, and the support received after the incident (UNFPA, 2012). One reaction is to blame themselves for the rape (Burt &
Demello, 2002; Frese, Moya & Megius, 2004) and to exhibit high levels of emotional and cognitive distress, including helplessness, loneliness, sadness, and a desire for revenge, which are some of the general symptoms of depression (Atkeson et al., 1982; Horowitz, 1986). Survivors may make negative self-statements and exhibit cognitive distortions associated with depression including restlessness, sleeplessness, fearful thoughts, and poor appetite (Pauwels, 2002). They may feel extremely tense, humiliated, and guilty about the experience, may blame themselves for not fighting the perpetrator hard enough, and may develop revengeful thoughts associated with the rape. Kilpatrick, (2000) reported that survivors may have different immediate reactions after rape: some exhibit shock and distress through words and tears, while others have more internalized suffering.

Some research has focused on how rape affects women and girls, but few studies have explored the psychological effects of rape among Ghanaian and Liberian women and girls, despite the high prevalence of rape in these countries. Some psychological units in local hospitals in Ghana have found that survivors of rape develop a variety of serious psychological disorders including depression. Some survivors are extremely traumatized and may refuse to associate with men, even rejecting treatment by male doctors (UNHCR, 2010). Decker and Naugle (2009) reported that survivors of rape with a history of counselling exhibit lower levels of depression; counselling can provide victims with therapeutic skills and coping strategies so they can focus on the future, become more self-reliant, and move forward with their lives (Foa, Zoellner & Feeny, 2006; Kay, Jost & Young, 2005).

We hypothesized that in our population, the frequency and extent of depression would differ depending on the context and/or circumstances under which the woman was raped, as well as whether or not they received counselling. Ideally, the findings will inform policymakers in Ghana about the necessity of providing counselling for rape victims, and will further inform the UN about the success of their counselling program in the Budumburam refugee camp.

Note on impetus for the study: I have worked as a volunteer in refugee camps in Ghana for some time. The country acts as a host to several influxes of refugees from neighbouring African countries, and my frequent interactions with refugee women and girls, particularly at the Budumburam refugee camp, motivated me to understand their situation, especially how they are affected by rape. The UNHCR facilitated a counselling program at the Budumburam camp, which provided an opportunity for me to compare the psychological effects of rape among women who did and did not receive counselling. My primary objective was to explore depression levels among Ghanaian and Liberian survivors of rape, whether these were affected by being raped.
by familiar versus stranger perpetrators. I was also interested in determining the counselling they had received mitigated the depression.

METHODS

Recruitment

We recruited a convenience sample of 60 women from the Budumbura refugee camp in Ghana, the University of Ghana, and DOVVSU: 30 female survivors of rape and 30 females with no history of rape. Survivors were divided into two groups: 15 Ghanaian women from the University of Ghana (referred by DOVVSU), and 15 Liberian women from the Budumbura refugee camp in Ghana. The 15 Liberian participants received counselling, while the 15 Ghanaian participants did not. The control group included 15 Liberian women from the Budumbura refugee camp and 15 women from the University of Ghana campus who had not been raped. Participants ranged in age from 12–60 years (mean 30–39 years). Inclusion criteria for Ghanaian participants included survivors receiving services from DOVVSU and Ghanaian female students studying at the University of Ghana, Legon. Inclusion criteria for the Liberian participants were that they lived at the Budumbura refugee camp and either had experienced rape during the Liberian civil conflict or, if they had not been raped, had not experienced other traumatic events in their lives which could have an impact in their psychological coping. Some Liberian participants who had been raped received counselling and some did not (see Table I).
Table I: Participant Demographics

<table>
<thead>
<tr>
<th>Survivor Group</th>
<th>Age (N)</th>
<th>Other bodily harm, e.g., slapping, kicking (N=25)</th>
<th>Resultant STD (N=1)</th>
<th>Pregnancy (N=2)</th>
<th>Stranger rape (N=15)</th>
<th>Close relation (N=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/19</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>20/29</td>
<td>7</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>30/39</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>40/49</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>50/60</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Participation was voluntary and participants were informed that they could leave the study at any time. Participants were debriefed after the study and those with post-research emotional difficulties were provided with psychological counselling. They were also informed that results and recommendations from the study would be made available to policymakers. Ethics approval was obtained from the University of Ghana, Legon Ethics Committee. With regard to the 12-year-old participant, parental consent was provided under the supervision of DOVVSU before the commencement of the study; as in Canada, persons younger than 16 may not participate in a study without parental consent. For the sake of privacy, all interviewees are anonymous.

Questionnaires

A semi-structured questionnaire was devised from validated instruments as follows:

Section A: Section A consisted of demographic information: age, sex, marital status, occupation, educational background, residential location, STI/HIV status.

Section B: Section B consisted of structured and unstructured questions. Five statements were designed to assess characteristics of the rape, and four statements were related to psychological difficulties attributed to the rape. Items included standard questions from the Beck Depression Inventory (BDI) and open-ended questions about social/demographic background. The BDI questions were selected after
a pilot study involving five survivors referred by DOVVSU ensured that they were culturally relevant to the population being studied. Examples include: I don't feel disappointed in myself, I am disappointed in myself, I am disgusted with myself, I hate myself; I do not feel sad, I feel sad, I am sad all the time and I can't snap out of it, I am so sad and unhappy that I can't stand it. Standard BDI cut-off scores were used to assess depression (Beck, 1996): higher scores suggested symptoms of depression and lower scores suggested an absence of depressive symptoms.

Section C: Section C consisted of a scale from the Center for Epidemiology Studies: The Depressed Mood Scale (CES-D). This short standardized self-report scale is designed to measure depressive symptomatology in the general population. It includes 20 items selected from various sources: the Zung Self-Rating Depression Scale (Zung, SDS), the Beck Depression Inventory (BDI), the Raskin Scale, a depression checklist developed by Gardner (1968), and the Minnesota Multiphasic Personality Inventory Depression Scale (MMPI-D). Four of the items are worded in a positive direction to control for response bias. Subjects are asked to rate each item on a scale from 0 to 3 on the basis of “how often you have felt this way during the past week”: 0 = rarely or none of the time (less than 1 day), 1 = some or a little of the time (1-2 days), 2 = occasionally or a moderate amount of time (3-4 days), and 4 = most or all of the time (5-7 days). CES-D scores range from 0-60: higher scores indicate more severe depressive symptoms. Total severity is calculated by reversing scores for items 4, 8, 12, and 16 (the items that control for response bias), then summing all of the scores. A score of 16 or higher is considered to indicate current depression. Although the CES-D is not a bona fide questionnaire for diagnosing depression, it was appropriate for use in this study because it is widely used by psychologists in Ghana and other African countries. Moreover, the reliability and validity of the CES-D have been tested in African American, Asian American, French, Greek, Hispanic, Japanese, and Yugoslavian populations (Naughton & Wiklund, 1993). The CES-D has been translated into several languages, including Chinese (Cantonese and Mandarin), French, Greek, Japanese, and Spanish. Its internal consistency (measured by Cronbach’s alpha) is high across a variety of populations (generally around 0.85 in community samples and 0.90 in psychiatric samples). Split-half reliability is also high, ranging from 0.77-0.92. Test-retest reliability studies ranging over 2-8 weeks reveal moderate correlation coefficients (r = 0.51-0.67), which is desirable for a test of symptoms that are expected to change over time. Studies of African American compared with Anglo-American compared with Mexican American respondents revealed no differences in measures of internal consistency reliability (Roberts, 1980).
Questionnaires were back-translated into the Ewe, Twi, and Ga languages to ensure that the meanings approximated the English version of the questionnaires.

**Counselling**

A total of 15 Liberian women living in the Budumbura refugee camp received cognitive behavioural therapy (CBT). The camp had approximately 10 CBT groups, each with 6–8 members, from which we recruited 15 women. Using a standard CBT approach for groups that was UNHCR approved, weekly group sessions were provided by trained clinical psychologists who were affiliated with the University of Ghana and Ghana Medical School. Sessions lasted for approximately 2.5 hours/week and continued for 6 months. All sessions were all held in a private space at the UNHCR office in Accra.

**Data Analysis**

Data analyses were conducted using SPSS statistical package version 16. Data were mainly ordinal (depression), so the t-test for independent sampling was used to test hypotheses.

**RESULTS**

Participation remained stable: only two of the originally recruited participants dropped out at the outset of the study. These were replaced by two other survivors who met inclusion/exclusion criteria. Participant demographics included: elementary, high school/university education, corporate employment, business acumen, marriage, and position of community responsibility. Only 10% of participants had no formal education; 68.1% reported elementary and high school education, while 21.9% reported post-graduate education. Overall, 4.8% reported being grandmothers, 73% were either married or in a committed relationship, and 22% identified as single or divorced.

**Hypothesis 1:** Survivors of rape will exhibit higher levels of depression than non-victims.

Participants who had been raped reported nightmares, sleeplessness, hopelessness, worry, helplessness, intense sadness, and low appetite. They also worried about having contracted sexually transmitted infections such as HIV. Two participants became pregnant as a result of the rape, but almost all participants worried about becoming pregnant during and after the assault and the consequent public shame and stigmatization. One 42-year-old Liberian participant said that she was gang-raped on her way to fetch water from a public water tap. She said that she cried for weeks; she was unable to handle the shock and felt...
ashamed and humiliated. A Ghanaian participant said she was returning home from an evening social program when she was threatened with a knife and then raped. A 60-year-old Liberian participant reported being raped twice during her escape to Ghana: once in a local refugee camp in Liberia and once during transit to Ghana. The stories told by both Liberian and Ghanaian participants revealed the traumatic nature of the rapes, and quantitative results demonstrated that significantly more victims had a CES-D score greater than 16 (indicating higher levels of depression) than did non-victims (t = 7.65, df = 58, P < 0.05; Table II).

### Table II: Scores & Comparison on Scores on CES-D

Summary of means and standard deviations of survivors & non-victims who scored 16 or higher

<table>
<thead>
<tr>
<th>Variables</th>
<th>No. of cases</th>
<th>Mean (x)</th>
<th>Standard deviation (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victims</td>
<td>30</td>
<td>61.8</td>
<td>±17.9</td>
</tr>
<tr>
<td>Non-victims</td>
<td>30</td>
<td>29.1</td>
<td>±15.1</td>
</tr>
</tbody>
</table>

T-test results of depression levels among victims & non-victims

<table>
<thead>
<tr>
<th>Variables</th>
<th>X</th>
<th>DF</th>
<th>T. Value</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victims</td>
<td>61.8</td>
<td>58</td>
<td>7.65</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Non-victims</td>
<td>29.1</td>
<td>58</td>
<td>7.65</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

P*= difference was statistically significant

Hypothesis 2: Women raped by close relations will exhibit higher levels of depression than those raped by strangers.

We found a statistically significant difference in depression level depending on whether a woman was raped by a close relation or by a stranger. Those raped by close relations exhibited higher levels of depression than those raped by strangers (t = -2.89, df = 28, P < 0.05; Table III).
Table III: Levels of Depression

Women with CES-D score of greater than 16 (those raped by close relations & those raped by strangers)

<table>
<thead>
<tr>
<th>Variables</th>
<th>No. of cases</th>
<th>Means (X) %</th>
<th>Standard deviation (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victims raped by close relations</td>
<td>15</td>
<td>70.3</td>
<td>±10.7</td>
</tr>
<tr>
<td>Victims raped by strangers</td>
<td>15</td>
<td>53.4</td>
<td>±19.8</td>
</tr>
</tbody>
</table>

T-test results of depression levels among women raped by close relatives & those raped by strangers

<table>
<thead>
<tr>
<th>Variables</th>
<th>X</th>
<th>DF</th>
<th>T-Value</th>
<th>P*</th>
<th>Ghanaians</th>
<th>Liberians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victims raped by strangers</td>
<td>53.4</td>
<td>28</td>
<td>-2.89</td>
<td>&lt;0.05</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Victims raped by close relations</td>
<td>70.3</td>
<td>28</td>
<td>-2.89</td>
<td>&lt;0.05</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

p*= difference was statistically significant

Hypothesis 3: Counselling reduces the level of depression among women who were raped.

We hypothesized that counselling would reduce depression levels or symptoms among survivors who were depressed. The data revealed statistically significant differences between those who received counselling and those who did not (t=4.16, df= 28, p=<0.05; Table IV). Respondents with counselling experienced lower levels of depression than respondents who received no counselling, even though those who received counselling were in exile and still lived in a refugee camp.
Table IV: Counselling & Depression

<table>
<thead>
<tr>
<th>Variables</th>
<th>No. of cases</th>
<th>Mean (x)</th>
<th>Standard deviation (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survivors with counselling (Liberian women)</td>
<td>15</td>
<td>51.0</td>
<td>±17.7</td>
</tr>
<tr>
<td>Survivors without counselling (Ghanaian women)</td>
<td>15</td>
<td>72.7</td>
<td>±9.7</td>
</tr>
</tbody>
</table>

Depression levels among women who were counselled post-rape those who were not

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean (X)</th>
<th>DF</th>
<th>T-Value</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape survivors with counselling (Liberian women)</td>
<td>51.0</td>
<td>28</td>
<td>4.16</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Rape survivors without counselling (Ghanaian women)</td>
<td>72.7</td>
<td>28</td>
<td>4.16</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

p*= difference was statistically significant

DISCUSSION

A relatively large body of literature focuses on rape in general, but to date no studies have focused on the repercussions of rape and defilement among Ghanaian and Liberian women, who live in cultures where sexual violence is rampant. This study revealed that in these populations, the frequency of depression is higher among women who have been raped. It also revealed that cognitive behavioural therapy, even for a limited time, reduces the frequency of depression.

Generally, the findings indicated that Ghanaian and Liberian women who have been raped experience similar psychological difficulties, despite the different locations and circumstances of the rape. This finding has been well documented in other regions of the world, but this is the first study to document it among Ghanaian and Liberian women.

Hyman and Williams (2001) and Kilpatrick et al. (2007) reported that survivors of rape experience a variety of mental health issues, including depression, suicide attempts, post-traumatic stress disorder, anxiety, depression, eating disorders, and sleep disorders. We found that women who had been raped were more likely to be depressed at the time of the interview than women who had not been raped. They were also more likely to report nightmares, sleeplessness, hopelessness, worry, helplessness, intense sadness, and low appetite, and worried about having contracted sexually transmitted infections such as HIV. Fear of HIV has been found to increase depression; researchers in
Thailand (Millian & Millian, 2009) found that while only 1 in 10 victims of rape contracted a sexually transmitted disease, victims developed emotional and psychological strain related to fears about contracting HIV or getting pregnant, in some cases severe enough to lead to suicide. Although we did not specifically investigate the incidence of HIV among victims, it is possible that the fear of having contracted HIV may be associated with the experience of depression.

Our participants referred to being embarrassed and stigmatized by society if they became pregnant. In Liberia and Ghana, young unwed women who become pregnant are usually expelled from school, regardless of the circumstances that led to their pregnancy. They may also be abandoned by their families and left to fend for themselves. Some are left on their own to pay for the medical expenses incurred by the rape (Ardayfio-Schandorf, 2005; Ark Foundation, 2011; Kuenyehia, 1998; UNFPA, 2011). Just as the fear of HIV may increase the likelihood of depression, fear that a rape may lead to pregnancy may also exacerbate depression.

We found that women assaulted by people familiar to them, such as close relatives, had higher levels of depression than those who were assaulted by strangers. In both Ghana and Liberia, more than 95% of reported rapes occur within a family relationship (Gender Centre, 1999 & 2010; UNFPA, 2011). In these cases, women feel betrayed by the people they trust and who are in a position of authority (Kilpatrick, et al., 2007; Kuenyehia, 1998). They may isolate themselves socially and stay away from others, compounding their psychological distress (Appiah & Cusack, 1999). Atkeson et al. (1982) found that women raped by close relatives tend to have more psychological disorders than those who are raped by strangers.

Our participants who received counselling had a lower frequency of depression than participants who did not receive any counselling. This supports the findings of Danquah (2005), Ardayfio-Schandorf (2005) and Gender Studies (2010), who also reported that women who receive counselling after rape tend to cope better and are better able to utilize other types of support offered them. Counselling is important because it can counter psychologically harmful coping mechanisms such as self-blame (Frazier, 2003; Frazier, Mortensen & Steward, 2005; Koss & Figueredo, 2004), which may lead to PTSD symptomatology (Filipas & Ullman, 2006; Frazier, Mortensen & Steward, 2005). Counselling may also act as a kind of community involvement and

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In an effort to provide help for survivors of sexual violence, DOVVSU collaborated with the government of Ghana to forge Ghana’s new Domestic Violence Act, specifying access to free medical treatment for survivors of sexual violence. While the act was passed in 2012, the law has yet to be implemented (DOVVSU, 2012).
may help women overcome barriers associated with stigmatizing cultural norms that undermine the benefits of reporting incidents. In particular, community-wide information about the availability of, and entitlement to, rape counselling and reporting may contribute to mitigating depression.

**Strengths & Limitations of the Study**

An important strength of this study is that it addresses the psychological outcomes of rape among women from two West African countries with extremely high rates of sexual violence, but in which few studies on rape survivors have been conducted. Another strength of the study is that it compares the effects of rape by perpetrators known and unknown to the victims. As well, it assessed whether counselling mitigates depression among women who have been raped. Limitations of the study include the use of a convenience sample, a wide age range, and education levels (some participants had difficulties reading and understanding the questionnaire). Another limitation is that the questionnaire was not validated for these particular groups of women and was translated into the Ewe, Twi, and Ga languages, which could mean that the exact meanings of the questions were not adequately conveyed. Additionally, the findings should be considered preliminary due to the small sample size, which did not allow sufficient power for statistical significance, especially in subgroup analyses.

**Policy Recommendations**

This study demonstrated that the frequency of depression is greater among women who are raped than those who are not. Ghana’s Domestic Violence Act should be implemented so that women can seek quick, easy, and affordable treatment. We also recommend that DOWSU and other local agencies work closely with professional mental health professionals including clinical psychologists, counsellors, and social workers, who can help survivors cope with the trauma and practical aftermath.

Because a general public attitude of ‘blaming the victim’ may contribute to victims’ depression, we recommend the creation of a nationwide public awareness campaign to challenge victim-blaming attitudes. Family members and caregivers should be educated, informed, and debriefed about the impact of rape on survivors. More crisis and rape treatment centres and hotlines should also be made available and advertised through various radio stations.

There is a need for societal and attitudinal change in both Ghana and Liberia, because patriarchy still dominates the personal and political life of women. Women should be supported and empowered economically, emotionally, and politically. Public resources should be
invested to enable access to free healthcare and other social services. Medical doctors, psychologists, social workers, and police officers in both countries need to face the problem and find strategies to prevent rape and help survivors. Both Ghana and Liberia have survivor intervention programs, but these need to be improved and made more accessible. Survivors of rape should be provided with free medical and psychological care, which should be covered by the health insurance scheme. Programs that focus on preventing rape should also be promoted, and should engage men and boys. Perpetrators should attend intervention programs that focus on behavioral change, to ensure they do not commit such acts again. Establishing family courts that will oversee rape and domestic violence cases is highly recommended. Finally, and most importantly, it is vital to work with men and boys to find ways to prevent rape and support more respectful, egalitarian relationships that will allow girls and women, men and boys to live safe and healthy lives.

REFERENCES


