Point of View

Addressing the mental health needs of adolescents becoming pregnant through statutory rape in Sri Lanka

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Introduction

The Ministry of Health reports that teenage pregnancies account for 6.5% of the pregnancies in Sri Lanka and 7.1% of these pregnancies are unwanted[1]. Rape related pregnancy is defined as a pregnancy occurring as a result of non-consensual sexual intercourse or consensual sexual intercourse with a minor[2]. According to Sri Lankan law, sexual intercourse with a girl below 16 years of age, with or without her consent, is considered as statutory rape[3]. Adolescent girls face health risks in pregnancy and childbirth which account for 15% of the Global Disease Burden for maternal disorders and 13% of maternal deaths[4]. Adolescent mothers, 15-19 years of age, are more likely to die in childbirth than older mothers. In that context, young mothers 14 years or younger are at highest risk[4]. For every young woman dying during childbirth, 30-50 others will be left with injury, infection or disease[4].

Pregnancy itself is a significant stress factor for teenage girls due to negative social attitudes and a huge social stigma. Adolescent mothers experience significantly higher rates of depression before and after the birth of the baby than adult mothers and non-pregnant peers[6-9]. Around 16-44% of adolescent mothers are estimated to suffer from depression whereas the lifetime prevalence of major depression in non-pregnant adolescents and adult women ranges from 5-20%[7]. Depressive symptoms in young mothers will more probably persist long after the delivery of their child[1]. Suicide rates in adolescent mothers range from 11-30%[12,13]. The negative psychological consequences of teenage pregnancies are likely to be intensified when the pregnancy occurs as a result of rape. There is ample evidence that pregnancy following rape is associated with various adverse psychological consequences such as adjustment disorder, post-traumatic stress disorder, anxiety disorders, depression, increased suicidal risk, substance use disorders, personality and relationship related issues. Therefore, though teenage pregnancies resulting from rape accounts for only a small portion of pregnancies in Sri Lanka, this population warrants special attention due to the associated negative outcomes.

In the Sri Lankan setting, management of adolescent pregnancy resulting from rape involves the participation of multiple stakeholders, including the obstetric team, the paediatric team, the psychiatric team, judicial medical officers, primary health care workers (public health midwives and medical officer of health), National Child Protection Authority, probation and social service department, divisional secretariat, police and the legal system. However, there is no national policy or guideline in Sri Lanka to streamline the management approach by each stake holder within their professional expertise. This has resulted in different approaches by different parties making the pregnant teenager further psychologically traumatized even within the system. Several practices used in the management of adolescent pregnancies in Sri Lanka may worsen the psychological trauma in these adolescents. In many instances adolescents are not given adequate support during labour including pain relief, emotional support and maintaining privacy, all of which can add to their emotional trauma. Many teenage girls who have become pregnant through rape are forced to breast feed for months while awaiting the baby to be handed over to probation services. In addition, teenagers who have been admitted to residential care for teenage mothers for protection during pregnancy, remain in these institutions for a prolonged period due to delays in legal procedures. Such prolonged institutionalization can lead to disruption of their education and make it more difficult for them to integrate into society. There is also a lack of documentation on experiences in these

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groups of adolescents. This article describes the experiences of four teenagers who became pregnant as a result of rape, with special attention to deficiencies in the services and recommendations for future developments.

Case 1

A 13-year-old girl, who had become pregnant following rape, was referred to the Child and Adolescent Mental Health Services (CAMHS) at 36 weeks of pregnancy. She was residing in a care facility for teenage mothers, away from her family. She had an intellectual disability with a mental age of 6 years. She had never been to school, could not read or write and had a poor concept of time but was independent in her activities of daily living. She had poor understanding of sexual intercourse, pregnancy and childbirth. Her main concern was being separated from her family. Neither she nor her family wished to keep the baby. She had no evidence of a psychiatric disorder. She had a normal childbirth and had been advised to breastfeed by the obstetric ward in keeping with routine practice, to which she had agreed reluctantly. In the case conference which was held immediately after the childbirth, a decision was made to handover the newborn to alternative care. Due to delay in legal procedures, she returned to residential care where she continued breastfeeding reluctantly. She had continuous difficulties with breastfeeding and had been referred for breastfeeding support by the obstetric ward. She was referred to the consultant paediatrician, who advised her to stop breastfeeding and started her on formula feeding. A repeat case conference was held and after a 2-month delay, the baby was handed over to alternative care and the child was sent back home.

Case 2

A 15-year-old girl was referred to CAMHS at 35 weeks of pregnancy, following rape. She was residing in a care facility for teenage mothers. She had no contact with family during her stay at the residential care facility and she worried immensely about being away from her family. She was very anxious and fearful of childbirth and did not want to go through a normal vaginal delivery. She had no evidence of psychiatric illness. Neither she nor her family wished to keep the baby. A case conference was held prior to delivery and delivering the baby through caesarean section was recommended, to minimize psychological trauma. Separation of the mother and baby at birth, formula feeding and handing the baby to alternative care as soon as possible were recommended. Prior to the delivery she became highly anxious and was started on a short course of alprazolam. Due to the legal formalities, following childbirth she was returned to the residential care facility with the newborn, despite the recommendations.

Case 3

A 16-year-old girl, with a 9-month-old infant was brought to CAMHS from a residential care facility for teenage mothers. She had become pregnant following incest and sent to residential care during pregnancy. She had not wanted to keep the baby at the time of birth and still did not wish to keep her baby. A decision had been made immediately following childbirth to handover the baby to alternative care. Due to delays in the legal procedures, she was still in residential care with her baby and was breastfeeding the infant as advised by staff, with great reluctance. She complained of depressive symptoms since the birth of the baby and had suicidal thoughts with no active plans. She also had thoughts of abandoning the baby and running away. She had minimal eye contact with her baby and avoided the baby's gaze when breastfeeding. She had low mood, lack of interests and loss of appetite. A moderate depressive episode was diagnosed and she was commenced on Sertraline. The department of probation was contacted and updated about the mother's mental state and was recommended to speed up the legal process. The mother was sent home two months later after completion of the legal procedures.

Case 4

A 16-year-old girl was brought to CAMHS with her 6-month-old infant. She had become pregnant following rape and was admitted to residential care during pregnancy. A decision had been made immediately after childbirth to handover the baby to alternative care, as neither she nor her family had wanted to keep the baby at the time. However, due to delay in legal procedures, she had been returned to residential care with her baby. For 6 months, she had breastfed the baby and been the baby's primary caregiver. By the time the legal procedures were completed, she had developed a strong attachment to her baby and refused to give him up. However, as she lacked social and financial support to raise her infant and her parents were not willing to support her to raise the baby, the baby was handed over to alternative care as planned. Following this she developed a moderate depressive episode with suicidal thoughts and had to be started on medication.

Discussion

These cases describe the reality of rape related teenage pregnancy in Sri Lanka. The Sri Lankan law permits abortion only where there is a threat to the mother's life. Due to the high risk of physical and psychosocial effects of rape related teenage pregnancy, abortion laws should be revised to permit rape victims the choice of terminating their pregnancy. According to the Children and Young Persons Ordinance (CYPO) Sri Lanka, all children who become pregnant following rape are admitted

to residential care for protection. Such facilities are situated only in a few districts in Sri Lanka. Therefore, teenagers often have to be sent far away from their families. As described in two of the above cases, some children are more distressed about being away from their families than the rape or the pregnancy. Social support is a main factor that affects the psychological outcome of rape[13]. Moving the child to a care facility far from home takes the child away from their main social support. Therefore, measures need to be taken to manage these children close to home. However, there is evidence from literature to suggest that parents themselves often want their sexually abused children to be admitted to residential care due to fear of stigmatization[15]. Therefore, managing these children close to home is not possible without interventions to reduce the stigma against victims of rape.

In the second case described above, the victim was extremely anxious and fearful of childbirth and did not wish to undergo normal delivery. The adolescent's fear of childbirth has been known for ages. Unlike an adult woman's desire to master the childbirth experience, adolescents found childbirth a frightful[16] and painful experience[17] to be survived rather than a potentially positive life transition. Anderson C, *et al*[16] found that around 30% of adolescents assessed their childbirth as traumatic and that 50% displayed symptoms suggestive of acute trauma immediately after birth. Those with a history of sexual abuse are at a much higher risk of developing negative psychological consequences.

Childbirth may provoke memories of past sexual abuse and may be recognized as being like a repetition of a past abusive experience by some of the survivors. The lack of privacy, manipulation of genital organs, the vaginal and rectal trauma, pain and the lack of control experienced by some females during labour, may all trigger memories of past abuse[18]. This may make childbirth especially challenging for adolescents who have become pregnant through rape. Such victims may experience re-traumatizing, flashbacks and dissociation during childbirth[18]. The re-experiencing of abuse can be compounded by insensitivity to the psychological status of the patient. Given the rate of acute trauma reported by adolescents during childbirth, a special focus on the mental health of adolescents during and following childbirth is also needed. Follow-up by mental health professionals to assess the potential chronic trauma, post-traumatic stress and depression is needed[19]. Assistance with pain control is also of the utmost importance as this was identified as the most important supportive behaviour desired by adolescents[19]. Adolescents are often unaware about the options for pain management. Therefore, they should be educated on the available options and guided to make the optimal choice of pain management. When supporting an adolescent during labour, the nurses should keep in mind that the adolescent does not have the psychological and cognitive development of an adult and support should be provided accordingly[19]. Labour support behaviours appreciated by teenagers include praise, respect, truthful answers to queries, distractions, and assistance in breathing and relaxing[20].

Sri Lanka has a high emphasis on breastfeeding. Exclusive breastfeeding is recommended for the first six months after birth as it can reduce infant mortality by 13%[21]. Therefore, the standard practice in Sri Lanka is for victims of rape to breastfeed their infants. Although the benefits of breastfeeding cannot be denied, research shows that adolescents require to attain a certain developmental stage before they can choose breastfeeding as the method of feeding their infants[16]. An adolescent's conflicts about her body image and ambivalence about breasts as sexual objects can be a major barrier to a decision to breastfeed[21]. Several researchers state that many adolescents find breastfeeding repulsive[23,24].

Worries about body image (e.g., breast disfigurement) as well as embarrassment have also been found as reasons to make adolescents unwilling to breastfeed[25]. In addition, breastfeeding may be impossible for an adolescent who wishes to return to school following delivery, especially in the Sri Lankan context where adolescent pregnancies are strongly stigmatized and where there are no breastfeeding support systems within schools. In addition, experience of sexual abuse may make breastfeeding especially difficult for affected women. Victims of rape are more likely to suffer higher rates of physical and psychological consequences when breastfeeding. For example, one study found that compared to controls, females with a history of sexual abuse are more likely to experience mastitis and pain during breastfeeding compared to controls. This study reported that 20% of women reported breastfeeding to trigger memories of their past abuse[26]. The skin-to-skin contact with their babies, milk ejection reflex and the physical sensation of milk in their breasts may act as potential triggers to re-experiencing trauma during breastfeeding. In this study, 58% of females with a history of sexual abuse experienced dissociative symptoms due to triggering of past trauma while breastfeeding[27]. The impact of sexual abuse on breastfeeding needs to especially be taken into account in adolescents, as many of them become pregnant as a result of sexual abuse.

Recently, the importance of guiding the mother in accord with her wishes has been emphasized[27,28] and it has been highlighted that by not taking the patient's wishes into account, the healthcare workers

invalidate the patient as an expert on his or her life[29]. However, in three of the above cases, the victims were forced to breastfeed their newborn despite their reluctance and a clear plan of separation of the mother and the child, which can predispose to mental health consequences in the mother. In addition, as described in the fourth case, breastfeeding may lead to development of bonding and attachment between the mother and the child, which may make the mother vulnerable to develop psychological consequences upon separation.

Common to all the above cases is the delay in legal procedures, which lead to these children being institutionalized for prolonged periods. Prolonged institutionalization is likely to disrupt their education and make community integration especially difficult for these victims. Therefore, measures should be taken to speed up the legal procedures so that the children can be sent back to the community as soon as possible. Furthermore, the management of pregnancy following rape in Sri Lanka differs between institutions due to the lack of National Guidelines. Given the psychosocial adversities associated with rape related pregnancy, urgent measures need to be taken to formulate a national guideline for management of these victims.

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