Mental health and psychosocial support interventions for survivors of sexual and gender-based violence during armed conflict: a systematic review

Sexual violence has been defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (1). Gender-based violence is a broader umbrella term referring to any harmful act that is perpetrated against a person based on socially ascribed (gender) differences between males and females.

Rates of sexual and other forms of gender-based violence are typically higher in areas of armed conflict than in non-conflict settings (2). Sexual and gender-based violence during conflict is not restricted to rape, nor does conflict-related violence end when conflicts do. Furthermore, the prevalence of sexual violence by intimate partners is usually higher than that of sexual violence by strangers (3).

Sexual and gender-based violence has been associated with a high prevalence of social problems (such as social exclusion), psychological distress and mental disorders, including anxiety disorders (such as post-traumatic stress disorder), mood disorders, and substance use disorders (4).

International consensus guidelines for prevention and response to sexual and gender-based violence and for mental health and psychosocial support in emergency settings exist (5,6). However, despite the increasing implementation of these interventions, there is a wide gap between popular practices and knowledge on effectiveness of interventions (7).

We conducted a systematic review on the impact of mental health and psychosocial support interventions for survivors of sexual and gender-based violence during armed conflict. Grey (i.e., evaluations published on websites, humanitarian reports, etc.) and academic literature were searched between May 13 and August 30, 2011.

With regard to grey literature, we searched the Internet (Google) using identified territories where armed conflicts were recorded between 2001 and 2009 as keywords, in combination with Boolean phrases (available upon request) to narrow the search to: sexual and gender-based violence, mental health and psychosocial well-being outcomes, and a broad range of interventions. In addition, we searched 14 websites of key agencies and initiatives in this field for relevant reports.

For the academic literature we searched the Cochrane Database of Systematic Reviews, Cochrane Controlled Trials Register, PubMed/Medline, PsycINFO, and PILOTS. We examined reference lists of a number of relevant reviews and of included evaluation studies. We contacted key authors in the field to find out whether they were aware of further studies that would meet inclusion criteria. Studies were included if they were conducted with survivors of sexual or gender-based violence in areas of armed conflict, described a mental health or psychosocial support intervention, and reported evaluation methodology.

We searched without date limitations and limited our search to reports in English. Quality of papers was assessed using the Downs & Black's checklist for the assessment of the methodological quality of studies of health care interventions (8).

Out of 5,684 returned records, 189 full text papers were assessed for eligibility and seven studies met inclusion criteria (9-15). One was a non-randomized controlled study; three applied non-controlled pre-posttest designs; one was a retrospective cohort study with a comparison group; and two were single case studies. Four studies were conducted in West and Central Africa, two were conducted with refugees in the USA, and one was conducted in Albania.

Studies included women exclusively and evaluated more generic multidisciplinary interventions (e.g., group counseling or support groups, combined psychosocial and economic interventions, medical care and psychological support) or specialized psychotherapeutic interventions (such as cognitive behavioral therapy). The quality of studies ranged from 12 to 16 out of 27 items on the Downs & Black's checklist (8), indicating substantial limitations in study design and reporting.

An obvious conclusion from this systematic review is that the number and quality of conducted studies does not match the significance of the problem. The extent to which knowledge from other types of populations, for example those affected by disasters (7), is generalizable is not known. No studies were found with children below 14 years of age, male participants, and survivors of intimate partner/domestic violence in conflict-affected areas, despite this being a more common form of violence than rape by armed groups. In addition to their relative scarcity, it is difficult to draw any robust conclusions from the identified evaluation studies because of serious methodological limitations.

Nonetheless, the seven studies together point to potential beneficial effects of intervention, and no harmful effects of treatment were reported. Despite their limitations, the studies suggest that evaluations of popular interventions can be conducted in challenging situations through partnerships between academia and implementing organizations. Such

efforts are crucial to strengthen evidence of effectiveness or potential harm and provide accountability to stakeholders in real-world settings. More focused research efforts are urgently needed to isolate the effects of specific strategies that improve well-being and prevent or manage mental disorders and psychosocial problems in people who have survived sexual and gender-based violence in conflict settings (16).

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