

## REVIEW ARTICLE

# Health and social consequences for survivors of genocidal rape: A systematic scoping review

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## Abstract

The unique forms of trauma experienced by survivors of genocidal rape are not well understood. Hence, we conducted a systematic scoping review regarding the consequences for survivors of rape during genocide. Searches conducted in PubMed, Global Health, Scopus, PyscInfo, and Embase produced a total of 783 articles. After completing the screening process, 34 articles were eligible for inclusion in the review. The included articles focus on survivors from six different genocides, with most focusing on either the genocide of the Tutsis in Rwanda or the Yazidis in Iraq. The study findings consistently show that survivors deal with stigmatization as well as a lack of both financial and psychological social support. This lack of support is partly due to social ostracization and shame but is also attributed to the fact that many survivors' families and other providers of social support were murdered during the violence. Many survivors, particularly young girls, reported dealing with intense forms of trauma both as a direct result of sexual violence and due to witnessing the death of their community members during the period of genocide. A notable proportion of survivors became pregnant from genocidal rape and contracted HIV. Group therapy was shown to improve mental health outcomes across numerous studies. These findings have important implications and can inform recovery process efforts. Psychosocial supports, stigma reduction campaigns, community reestablishment, and financial assistance are integral in facilitating recovery. These findings can also play an important role in shaping refugee support programs.

The term genocide was first formally described by the General Assembly of the United Nations (U.N.) on December 9, 1948, as actions with the intent to eradicate, either wholly or partially, any particular population or populations by any particular means (U.N. General Assembly, 1948). Genocide is unique to war in that the perpetrators

systematically plan for the whole or partial extermination of a population purely based on some common social, political, or cultural identity (Campbell, 1998; Di Caro, 2019; Lang, 2017; U.N. General Assembly, 1948). With the goal of in-depth devastation, sexual violence and rape have been reported to be commonly used as powerful weapons

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of genocide (Di Caro, 2019). Unlike sexual violence in war, which tends to involve impulsivity and lustfulness, in genocide, it is strategic, purposeful, and indiscriminate and is used as a means to fulfill its goal of population control (Campbell, 1998; Di Caro, 2019). A review by Ba and Bhopal (2017) demonstrated that abandonment by one's community, depression, and pregnancy were among the most common consequences of rape after war.

Sexual violence and rape can act as instruments of genocide through multiple fronts. The physical and psychological trauma of sexual violence can make survivors unable to produce children, thus curbing population levels (Rogers, 2016). Furthermore, due to cultural and social norms, sexual violence can be used to isolate and humiliate individuals, bringing destruction to the culture and community when survivors are deemed to be undesirable and unfit for marriage or progeny (Short, 2003) and can be conducted to deliberately impregnate women and alter the resultant child's future identity for generations (Fisher, 1996).

With such devastation that reflects the pinnacle of crimes against humanity during genocide, a range of health and social consequences emerge, and need to be addressed. Although a review was conducted on sexual violence in the context of war (Ba & Bhopal, 2017), little is understood regarding the consequences of sexual violence in the context of genocidal rape. Therefore, the purpose of this work was to provide a systematic scoping review of the literature on the health and social consequences of genocidal rape.

## METHOD

This systematic scoping review has followed the Preferred Reporting Items for Systematic Review and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR; Tricco et al., 2018; Page et al., 2021). The steps involved in conducting the review were (a) formulating the research questions; (b) creating search terms in databases and conducting searches based on these terms; (c) selecting studies after removing duplicates and performing title, abstract, and full-text screening; (d) extracting relevant data; (e) summarizing and collating the results; and (f) reporting and describing the findings and implications. There was no registered study protocol for this systematic scoping review.

On March 20, 2023, searches were conducted in five databases: PubMed, Global Health, Scopus, PyscInfo, and Embase. As our population of focus was survivors of sexual violence during genocide, searches included relevant terms related to both sexual violence/rape and genocide. Search terms were grouped into those pertaining to sexual violence (e.g., "rape," "sexual violence," "sexual assault")

and terms related to genocide (e.g., "genocide," "genocidal," "Holocaust") All utilized search terms are listed, by database, in Supplementary Table S1.

Original research articles were eligible for inclusion if they included any number of individuals who were survivors of sexual violence during periods of genocide and provided some description of either the physical or mental health consequences or social consequences of the sexual violence. In addition, only studies written in English were eligible for inclusion. There were no restrictions placed on publication date or study type, and gray literature was eligible for inclusion.

After the initial searches were completed, two reviewers independently screened all articles. First, duplicates were removed. Next, articles were screened by title and abstract based on the inclusion criteria. The full texts of the remaining articles were analyzed, and studies were included in the review if they met the overall requirements. Discrepancies were discussed until consensus was reached. Data were extracted based on study characteristics; survivor demographic characteristics; and physical, psychological, and social consequences. Next, consensus was reached to address discrepancies. Data were then synthesized and described based on the most consistent trends observed. Finally, data were analyzed and the implications of the findings described.

## RESULTS

### Screening process

Searches from all databases produced 781 total articles, and two additional articles were retrieved from a grey literature search. After the removal of duplicates, 615 articles remained, and 164 remained after the title and abstract screening. A total of 34 articles met the inclusion criteria and were included in the review. Figure 1 presents a diagram of the screening and inclusion process.

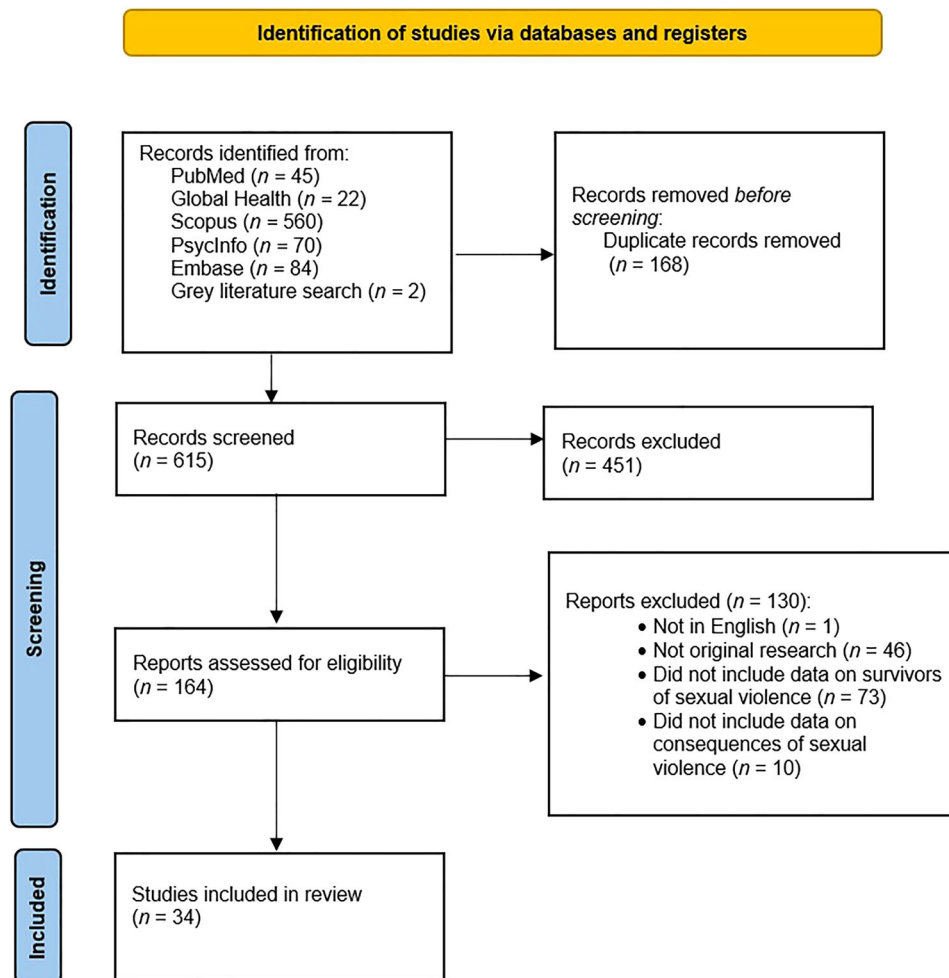
### Study characteristics

Table 1 presents an overview of the 34 studies, including the publication date, genocide location, number of included survivors, the proportion of female participants in the sample, and mean participant age (where available). Studies were published between 2004 and 2022, with 10 studies focusing on the genocide of the Yazidis, 17 on the Rwandan genocide, three on the Bosnian genocide, two on the Holocaust in Germany, one on the Armenian genocide, and one on the Guatemalan genocide. A total of 23 studies had a qualitative design, five had a cross-sectional design, two had a prospective cohort design,

**TABLE 1** Study characteristics and participant demographic characteristics

Study	Location	Study design	Sample size	% female	Age (years) (M)
Greaser (2018)	Iraq	Cross-sectional	NR	NR	40.2
Kizilhan et al. (2020)	Iraq	Cross-sectional	64 case, 60 control	100.0	25.61
Amnesty International (2014)	Iraq	Qualitative	42	100.0	
Human Rights Watch (2015)	Iraq	Qualitative	20	100.0	NR
Akhavan et al. (2020)	Iraq	Mixed methods: cross-sectional and qualitative	50	100.0	NR
Foster & Minwalla (2018)	Iraq	Qualitative	13	100.0	NR
Denkinger et al. (2021)	Iraq	Prospective cohort	116	100.0	32.2
Hoffman et al. (2018)	Iraq	Cross-sectional	108	100.0	24.4
Ibrahim et al. (2018)	Iraq	Cross-sectional	416	100.0	31.7
Vale (2020)	Iraq	Qualitative	22	100.0	NR
African Rights Organization (2004)	Rwanda	Qualitative	201	99.0	NR
Cohen et al. (2011)	Rwanda	Prospective cohort	349	100.0	36.7
Denov & Piolanti (2019)	Rwanda	Qualitative	44	100.0	NR
Hogwood et al. (2014)	Rwanda	Mixed methods: cross-sectional and qualitative	40	100.0	43
Kagoyire & Richters (2018)	Rwanda	Qualitative	15	100.0	NR
Kantengwa (2014)	Rwanda	Qualitative	17	100.0	41.1
Mukamana & Brysiewicz (2008)	Rwanda	Qualitative	7	100.0	32.1
Rubanzana et al. (2014)	Rwanda	Case-control	NR	NR	NR
Russell et al. (2016)	Rwanda	Qualitative	22	100.0	40
Sandole & Auerbach (2011)	Rwanda	Qualitative	30	100.0	32.8
Walstrom et al. (2013)	Rwanda	Qualitative	18	100.0	NR
Woolner et al. (2019)	Rwanda	Qualitative	44	100.0	NR
Zamperini et al. (2017)	Rwanda	Qualitative	20	100.0	NR
Zraly & Nyirazinyoye (2010)	Rwanda	Qualitative	44	100.0	40
Zraly et al. (2013)	Rwanda	Qualitative	63	100.0	NR
Zraly et al. (2011)	Rwanda	Qualitative	44	100.0	NR
Kahn & Denov (2022)	Rwanda	Qualitative	44	100.0	NR
Lev-Wiesel & Amir (2005)	Germany	Qualitative	22	36.4	68.3
Baldwin (2010)	Germany	Qualitative	NR	NR	NR
Crosby et al. (2016)	Guatemala	Qualitative	NR	NR	NR
Sisic (2019)	Bosnia	Qualitative	13	100.0	NR
Loncar et al. (2006)	Bosnia	Cross-sectional	68	100.0	32
Loncar et al. (2010)	Bosnia	Mixed methods: cross-sectional and qualitative	60	0	NR
Mutlu-Numansen & Ossewaarde (2015)	Bosnia	Qualitative	6	100.0	NR

Note: NR = not reported



**FIGURE 1** Review flow diagram

and one had a case-control design. There were also three mixed-method studies, all of which had a cross-sectional and qualitative design. A description of the study methodologies, including objectives, setting, data sources, and measures are listed in Supplementary Table S2.

Among the 34 included studies, three did not specify the number of participants, whereas the remaining studies' sample sizes ranged from six participants to 698 participants. The survivors ranged in age from 16 to 81 years. Of the 30 studies that provided information on survivors' gender, 96.2% of participants were female. However, the authors of one study noted that the number of male survivors might have been higher than the reported value (Loncar et al., 2010).

## Consequences of genocidal sexual violence and rape

The physical, psychological, and social consequences, by study, are listed in Supplementary Table S3.

## Physical consequences

Adverse health outcomes were classified as primary complications that directly resulted from rape, including pregnancy, HIV, injury, and castration, and secondary adverse health outcomes, defined as the indirect consequences associated with genocidal rape and aspects of genocide more generally, such as weight loss, self-neglect, and heart palpitations. The most frequently reported physical consequence was pregnancy. These pregnancies frequently resulted in numerous health complications. In a notable number of cases, the child was ultimately carried and birthed. Sexually transmitted infections, including HIV, were commonly noted, and HIV was frequently detected long after the rape (or multiple rapes) had occurred. Other frequently reported consequences were headaches, gastrointestinal symptoms, infertility, gynecological injuries and pain, long-term chronic pain, and sexual dysfunction.

The immediate and short-term consequences of genocidal rape and sexual violence included weight loss, head lice, a loss of appetite, hygiene issues, nausea and

vomiting, headaches, sweating, heart palpitations, pain, and physical injury, with some male survivors undergoing a full castration. Sisic (2019) also detailed some medium-term consequences, which were similar to the short-term consequences but further included vision loss and difficulties having sex. The reported long-term consequences included headaches, weight gain, spasms, illness, spine issues, and sexual dysfunction and other problems related to sexuality.

## Psychological consequences

Suicidality and suicide were the most frequently discussed psychological consequences across the included studies. For example, Vale (2020) noted that a high number of survivors reported previous suicide attempts. This study also noted that a significant number of genocide survivors completed suicide after surviving acts of sexual violence and to avoid becoming survivors of continual sexual violence and sexual slavery. Suicidal ideation was noted in numerous studies, particularly among mothers. Beyond suicide, participants reported shame, strong feelings of isolation, and affective disorders. Other consequences reported in numerous studies included posttraumatic stress disorder (PTSD), insomnia, anxiety disorders, anger, intergenerational trauma, flashbacks, and disturbances in identity. Kizilhan et al. (2020) noted that 100.0% of participants had PTSD. These individuals with PTSD were shown to be consistently at an elevated risk of other mental health issues, such as dissociative disorder, dissociative seizure, shame, and attempted suicide.

## Psychological interventions

In addition to psychological consequences, four studies evaluated the impact of psychological interventions (Cohen et al., 2011; Hogwood et al., 2014; Kagoyire & Richters, 2018; Walstrom et al., 2013). These interventions were psychosocial support groups and counseling interventions. Interventions were shown to reduce PTSD symptoms. One intervention, which provided psychosocial support in an HIV care setting, showed a decrease in cohort PTSD prevalence by 37% over the course of 18 months (Cohen et al., 2011). Other interventions involving group sessions with mothers of children born out of genocidal rape showed decreases in shame, increases in confidence, improvements in relationships with men, and improved adherence to HIV antiretroviral therapy (Hogwood et al., 2014; Kagoyire & Richters, 2018; Walstrom et al., 2013)

## Social consequences

Perceived stigma and social ostracism were prominent themes among the selected studies and were reported across 17 studies. Key causes of shame and social rejection included the repercussions of an HIV diagnosis, being a survivor of rape, and having a child or children with a perpetrator of genocidal sexual violence. In six studies, participants reported difficulties with marriage, with many hiding their past experiences of sexual violence to enable them to get married (Zraly & Nyirazinyoye, 2010). Eight studies recorded experiences and feelings of shame not only among survivors but also their families. Some studies noted that children born out of genocidal rape were often not accepted by the community and described difficulties in the mother-child relationship.

A loss of trust and social cohesion with both physical and cultural fragmentation continuing years after a genocide were additional social consequences (Akhavan et al., 2020; Vale, 2020). Six studies noted genocidal rape survivors' experiences with poverty and financial hardship (Crosby et al., 2016; Denov & Piolanti, 2019; Kahn & Denov, 2022; Kantengwa, 2014; Russell et al., 2016; Walstrom et al., 2013). Noted poverty-related issues included poor access to medical care and associated resources and the loss of housing. In Guatemala, although governmental financial assistance was available to survivors, participants noted that it was challenging to attain, as applicants needed to prove that they had survived sexual violence and many were dismissed by staff members (Crosby et al., 2016).

Akhavan et al. (2020) noted that many survivors of genocidal rape seek justice, most preferring to go through the court system and some preferring a more retributive approach. Many participants also disclosed their experiences of journalists pressuring, misleading, and undermining the survivor's safety and the safety of their captive relatives (Amnesty International, 2014; Akhavan et al., 2020; Foster & Minwalla, 2018).

## DISCUSSION

This review demonstrates that survivors of genocidal rape face widespread issues in various domains. The literature highlights that genocidal rape has multiplicative burdens on survivors, as the consequences are intrinsically related to each other and experienced in totality. For example, some survivors who develop issues such as sleep problems and other recurrent physical health issues are at an increased risk of developing psychological disorders, and being diagnosed with HIV can also lead to being ostracized and socially rejected. Future research should seek

to explore which particular factors most negatively affect quality of life among survivors and their capability to recover.

There are numerous parallels and differences between the findings of our review and the findings on rape in the context of war. In both sets of circumstances, physical health issues, such as HIV and AIDS, sexual dysfunction, and gynecological injuries, have been denoted (Ba & Bhopal, 2017). Similarly, psychological issues including suicide, depression, and PTSD are widespread in both circumstances, as are social rejection and perceived stigmatization. However, there are notable differences. In the case of genocidal rape, our findings show that rates of psychological pathologies such as PTSD and suicide—both attempts and completed suicides—tend to be particularly high and may be higher than after wartime sexual violence. One possible explanation for this is that, alongside the act of rape, survivors' entire social support and community networks are destroyed during periods of genocide; therefore, a higher number of survivors may be at risk for social isolation and, hence, have fewer means of coping. This review highlights the devastating economic hardships survivors of genocidal rape face and reinforces that these hardships further compound difficulties in recovery and the development of resilience. These economic hardships may be more common in genocidal contexts than in settings of war. Again, a possible explanation for this may be the slaughtering of whole communities in genocidal settings as well as the destruction of property and belongings. Therefore, complete support for survivors cannot occur without the provision of financial support. The provision of funds for survivors, alongside assurances that employment opportunities will be offered, is necessary. Overall, these findings also demonstrate a need for future studies to determine the extent to which the occurrence of mass murder and community destruction impact rape survivors in genocidal contexts; this research will be important in shaping recovery efforts.

This work allows for the recognition of the devastating health and social consequences of genocidal rape so that the necessary health care systems can be funded, allowing survivors to heal and recover. In consideration of the high burden of psychological disorders among survivors, psychosocial supports, including counseling groups, need to be dedicated to survivors. Two studies showed that the provision of psychosocial support, either by trained professionals or by counseling groups attended alongside other genocidal rape survivors, has the potential to improve mental health outcomes and provide the social support and solidarity that many survivors greatly need (Cohen et al., 2011; Walstrom et al., 2013).

Critically, a number of survivors felt alienation even after moving to a new country as a refugee. Therefore,

in relation to strategies and interventions supporting survivors of genocidal rape, it is imperative that survivors' sociocultural context is taken into consideration. Traditional Western psychosocial approaches that focus on biomedical and individualistic styles of intervention have been seen as being highly ineffective, as they may overemphasize traumatic experiences and ignore significant cultural understandings of trauma that are necessary for recovery and healing (Denov & Piolanti, 2019; Blanchet-Cohen et al., 2017). Hence, a person-centered care approach is crucial for the optimal health and well-being of genocidal rape survivors. It is important to denote that many perpetrators have not faced repercussions for their actions. Therefore, an integral part of the healing process will revolve around ensuring that genocidal perpetrators face imprisonment through an effectively functioning legal system.

The World Health Organization (WHO; 2011) outlines a strategy that accommodates the cultural and social needs of severe rape survivors and provides a satisfactory model that can be used to help and treat them. Although this strategy was not created in the context of genocide-related sexual violence, it nonetheless can provide a base of treatment for future care that can be more specialized to meet the unique needs of genocidal rape survivors. The approach highlights that care needs to be multileveled and needs to advocate for the use of a combination of person-focused and community-focused care. Person-centered interventions, such as psychological first aid (WHO, 2011) and group psychotherapies (Bass et al., 2013) focus on an individual's specific needs, connecting them with their family and social and support networks. As demonstrated by the present findings, support in group settings can be valuable, particularly for individuals who have lost their loved ones to genocide, and group therapy provides individuals with a means of connecting with individuals who have also experienced these unique forms of trauma and barriers to recovery. Community-focused care services, such as safe social spaces and community education programs, can protect the survivor's dignity and improve their overall well-being through supportive settings (Kelly et al., 2011). This allows for deeper empathy and understanding of survivors, facilitating an environment conducive to healing. Critically, interventions should be inclusive, involving survivors in the design, evaluation, and delivery of an intervention. Furthermore, special care needs to be given to not aggravate deleterious outcomes, such as increased perceived stigma (WHO, 2011). More research is needed regarding the effectiveness of interventions and programs to support survivors of genocidal rape; this will be relevant in contexts where genocide has taken place as well as in contexts where refugees are accepted.

In addition to the relevance of these findings, it is important to acknowledge the limitations of this review. Inconsistencies in the reporting of the effects of genocidal rape limit the extent to which the findings can be quantified and generalized. Connected to this point, the effects of rape in the genocidal context are multifaceted and complex. For example, it is unclear which aspects of trauma are a direct result of sexual violence versus the slaughtering of loved ones and destruction of one's way of life. Future studies will have an important role in establishing what factors mediate or moderate adverse outcomes and recovery, respectively. Furthermore, the majority of the included studies were primarily focused on the genocide of the Tutsis and Yazidis. Although some literature exists on other genocides, such as the Bosnian, Armenian, and Guatemalan genocides and the Holocaust, there is a clear need for more studies focusing on these events as well as other past and present genocides. Lastly, there is a need to study the impacts on male genocidal rape survivors, which tend to be greatly underreported (Loncar et al., 2010). Future studies in this area will serve to provide more holistic and comprehensive findings to guide intervention-based care for all survivors of genocidal rape. Regardless of these limitations, this review provides many important insights into the lived realities of survivors as well as the many difficulties they are expected to face during the recovery process.

This review brings attention to the magnitude of the physical, social, and psychological consequences that genocidal rape survivors face. It is imperative that services provided to support survivors are multilayered, with a combination of person-centered and community-centered approaches, to allow for recovery to occur. Through funding and appropriate support, survivors may be able to heal more effectively.

## OPEN PRACTICES STATEMENT

This review was not formally preregistered. Requests for data or materials can be sent via email to the lead author at [kvarshney@deakin.edu](mailto:kvarshney@deakin.edu).

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

**How to cite this article:** Varshney, K., Chu, M. G., Shet, P., Hopkins, J., Braga, F., & Ghosh, P. (2023). Health and social consequences for survivors of genocidal rape: A systematic scoping review. *Journal of Traumatic Stress*, 36, 691–699. <https://doi.org/10.1002/jts.22936>