



Evidence-Based Psychosocial Interventions for Reducing Distress Among Displaced Women and SGBV Survivors

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Abstract

This study examined the effectiveness of evidence-based psychosocial interventions in reducing distress among displaced women and survivors of sexual and gender-based violence, addressing the persistent problem of trauma-related fear, anxiety, hopelessness, social withdrawal, and reduced coping capacity in humanitarian settings. The purpose was to determine whether intervention accessibility, perceived quality, participation frequency, safe-service trust, and barriers to support utilization significantly influenced distress reduction within a quantitative, cross-sectional, case-study-based design. The study drew on a sample of 220 displaced women and SGBV survivors from a defined displacement-affected case setting, where respondents had been exposed to counseling, group psychosocial support, peer/community support, or case management services. Data were collected through a structured five-point Likert-scale questionnaire and analyzed using descriptive statistics, correlation analysis, and multiple regression in SPSS. The dependent variable was distress reduction, while the key independent variables were accessibility of interventions, intervention quality, participation frequency, safe-service trust and survivor-centered care, and barriers to psychosocial support utilization. Findings showed strong overall perceived distress reduction, with the mean distress-reduction score reaching 4.06 out of 5, while the overall distress profile declined from 4.19 before intervention to 2.58 after intervention, reflecting a mean improvement of 1.61 points. Safe-service trust had the highest mean among service variables at 4.18 and emerged as the strongest predictor of distress reduction in regression analysis ($\beta = .36, p < .001$), followed by intervention quality ($\beta = .29, p < .001$), accessibility ($\beta = .21, p = .003$), and participation frequency ($\beta = .17, p = .011$), whereas barriers showed a significant negative effect ($\beta = -.19, p = .006$). The overall model was statistically significant, $F(5,214) = 46.83, p < .001$, explaining 52.2% of the variance in distress reduction ($R^2 = .522$). The study implies that psychosocial interventions are most effective when they are accessible, high-quality, repeated, and delivered through trauma-informed, safe, and survivor-centered care, with practical efforts to reduce stigma, fear of disclosure, and access barriers.

Keywords

Psychosocial Interventions; Distress Reduction; Displaced Women; SGBV Survivors; Trauma-Informed Care

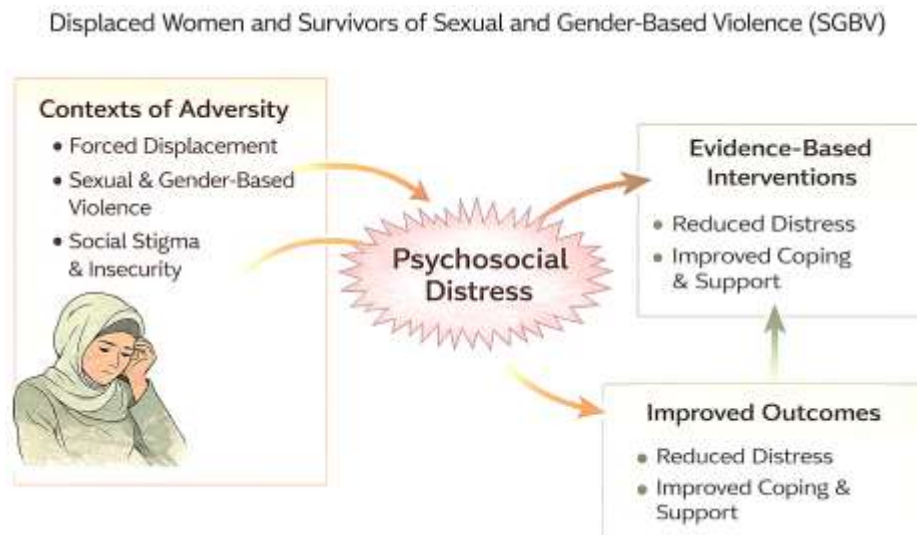
INTRODUCTION

Forced displacement refers to the involuntary movement of people from their homes because of armed conflict, persecution, generalized violence, or severe insecurity, while psychosocial distress refers to the broad emotional, cognitive, behavioral, and social suffering associated with overwhelming adversity. Within humanitarian and public health literature, sexual and gender-based violence (SGBV) covers acts such as rape, sexual assault, forced marriage, intimate partner violence, coercion, and other gendered forms of abuse that are rooted in unequal power relations (Bangpan et al., 2019; Bertl et al., 2022). Evidence-based psychosocial interventions, in turn, are structured supports whose content, delivery logic, and outcomes are informed by prior empirical research, clinical theory, and systematic testing. These definitions are central to the present study because displaced women and SGBV survivors occupy a position where political violence, family disruption, economic precarity, social stigma, and trauma-related symptoms converge in ways that are internationally significant (Khan et al., 2017; Porter & Haslam, 2005). Early meta-analytic and systematic evidence showed that refugees and internally displaced persons carry substantially elevated burdens of post-traumatic stress, depression, anxiety, and related disorders when compared with non-displaced populations, and that post-displacement stressors such as insecure housing, poverty, unemployment, and social exclusion are strongly associated with mental health deterioration. Research on conflict-affected populations also established that torture, repeated violence exposure, and cumulative traumatic events are associated with markedly worse psychological outcomes, which made mental health and psychosocial support a major concern within humanitarian response rather than a peripheral welfare issue. Further conceptual clarification showed that war-related adversity operates through both direct trauma exposure and everyday stressors, which means psychosocial distress among displaced women cannot be reduced to a single traumatic incident (Berry & Monk, 2020). This international significance was reinforced by humanitarian mental health reviews showing that crises affect not only psychiatric symptoms but also functioning, caregiving, trust, social participation, and community cohesion, all of which are highly relevant for women living with displacement and gendered violence. As a result, the current topic sits squarely within global health, gender justice, refugee protection, and humanitarian service delivery, because distress reduction among displaced women and SGBV survivors is tied to survival, dignity, recovery, and safe participation in social life (Greene et al., 2021; Jansen et al., 2015).

The international significance of this topic becomes sharper when attention turns specifically to women who experience displacement alongside sexual and gender-based violence. In such contexts, women are not only exposed to armed conflict and forced movement; they are also frequently subjected to forms of violence that continue during flight, in camps, in host communities, and inside intimate relationships. Studies from eastern Democratic Republic of the Congo documented that women survivors of sexual violence reported severe emotional suffering, social rejection, disrupted family relations, and difficulties reintegrating into community life, which shows that SGBV in humanitarian settings is both a psychological and a relational injury. Related research on gendered attitudes in the same context showed that humiliation, blame, and social judgement are woven into local responses to sexual violence, creating a wider climate of stigmatization that can intensify distress and limit help-seeking. It was also shown that stigmatization mediated the mental health burden among adolescent victims of sexual violence in eastern Congo, adding empirical support to the idea that symptoms are shaped by social response as much as by the original traumatic event (Ben-Zion et al., 2020; Bolton et al., 2014). This line of evidence is consistent with broader analyses showing that exposure to conflict and displacement increases the likelihood of depression, anxiety, and post-traumatic stress, while the ongoing environment of fear, dependency, material deprivation, and disrupted support systems maintains those conditions over time. For displaced women, psychosocial distress therefore emerges through an accumulation of losses: loss of bodily autonomy, loss of home, loss of social protection, loss of livelihood, loss of trusted networks, and loss of social status. Psychological interventions for survivors of intimate partner violence in low- and middle-income countries must be understood within this broader ecology of adversity, because emotional symptoms, safety concerns, and practical stressors are deeply interconnected. This makes displaced women and SGBV survivors a distinct analytical population rather than a simple subgroup within general refugee mental health research. Their distress profile contains trauma symptoms, shame, social withdrawal, fear of disclosure, and insecurity linked

to continuing violence, which means research on intervention effectiveness must remain attentive to both symptom relief and the broader psychosocial conditions in which recovery occurs (Miller & Rasmussen, 2010; Murray et al., 2014).

Figure 1: Pathways of Psychosocial Distress and Recovery in Displaced Women Experiencing SGBV



Within this literature, psychosocial interventions are generally understood as organized actions that aim to reduce distress, strengthen coping, restore social functioning, improve emotional regulation, and rebuild supportive connections. Their form varies widely, including individual counseling, group psychotherapy, cognitive and behavioral treatments, problem-solving approaches, guided self-help, peer-delivered supports, community sociotherapy, and integrated protection-plus-mental-health models. Humanitarian mental health and psychosocial support have been described as a field that links psychiatric knowledge, social care, community support, and protection concerns, which is especially relevant in settings where mental suffering is tied to violence, displacement, and rights violations (Bass et al., 2013; Bryant et al., 2017). The ADAPT framework placed safety, attachments, justice, roles, and meaning at the center of psychosocial recovery, giving a strong theoretical basis for studying how interventions may reduce distress among displaced populations whose social worlds have been fractured by conflict and forced migration. A later contribution introduced Problem Management Plus (PM+) as a World Health Organization transdiagnostic intervention for common mental health problems in adversity-affected settings, reflecting a shift toward scalable, evidence-based approaches that can be delivered by trained non-specialists. This emphasis on scalability and task-sharing is also found in reviews showing that humanitarian settings often have severe shortages of specialist providers, while the need for accessible and culturally adaptable mental health care remains very high (Kelly et al., 2012; Murray et al., 2018). Systematic evidence for refugee and asylum-seeker populations similarly points to the usefulness of psychosocial interventions, particularly when they are structured, manualized, and responsive to both trauma and ongoing stressors. At the same time, the literature shows that intervention effectiveness is not a purely technical question. Delivery format, trust in providers, privacy, gender sensitivity, cultural fit, and the degree to which an intervention addresses functioning and social support all influence outcomes. That is why a study focused on evidence-based psychosocial interventions for displaced women and SGBV survivors must treat intervention quality, accessibility, safety, and survivor-centeredness as central variables rather than peripheral program features. The concept of “evidence-based” in this field refers not only to clinical symptom change but also to how well an intervention aligns with lived realities of violence, social stigma, and displacement (Miller & Rasmussen, 2017; Turrini et al., 2019).

The most persuasive evidence on interventions for women affected by sexual violence in conflict settings comes from studies that directly examined female survivors and measured changes in distress, functioning, and social outcomes. A controlled trial among Congolese survivors of sexual violence found that group cognitive processing therapy reduced post-traumatic stress, depression, and anxiety symptoms and improved functioning relative to individual support, making it one of the most influential studies in this area. Related work later showed that group-based cognitive therapy also improved structural social capital among female survivors of sexual violence in the Democratic Republic of the Congo, which is highly relevant because psychosocial recovery in displacement settings is inseparable from the rebuilding of social participation and relational trust. It was later demonstrated that the same intervention had measurable effects on felt stigma among survivors of sexual violence in eastern Congo, indicating that psychological treatments may intersect with survivor identity and social belonging rather than operating only at the level of internal symptoms. These studies are important for the present topic because they show that distress reduction among women survivors can be documented quantitatively while still reflecting core psychosocial dimensions such as functioning, stigma, and connectedness (Weiss et al., 2015). They also reveal that evidence-based interventions can be delivered in conflict-affected settings by trained local providers, which strengthens the practicality of psychosocial treatment in low-resource humanitarian environments. At the same time, the Congo studies remain anchored to particular forms of violence and local service arrangements, which means their value lies both in demonstrating efficacy and in highlighting the importance of context-specific evaluation. For displaced women and SGBV survivors more broadly, the research record indicates that interventions work best when they are structured, relationally safe, and capable of addressing the intertwined burdens of trauma symptoms, shame, social exclusion, and impaired daily functioning (Verelst et al., 2014). This pattern is consistent with the argument that psychosocial recovery is not limited to symptom relief; it also involves restoring the person's capacity to move, relate, speak, trust, and act within social spaces that have often become unsafe after violence. Such findings make it reasonable to study distress reduction through measures that include both emotional suffering and psychosocial functioning in a displaced female population exposed to SGBV (Kamali et al., 2020).

A second major strand of literature concerns scalable interventions designed for women exposed to gender-based violence, post-conflict adversity, and forced migration. A randomized clinical trial in urban Kenya found that a brief behavioral intervention based on Problem Management Plus significantly reduced psychological distress among women with a history of gender-based violence, producing one of the strongest demonstrations that a brief, non-specialist-delivered intervention can benefit women living under chronic adversity (Kelly et al., 2011). In rural Pakistan, the feasibility and acceptability of a group World Health Organization transdiagnostic intervention for women with common mental disorders was established, and later evidence also showed that a brief group psychological intervention was effective for women in a post-conflict setting. These studies matter for the present research because they confirm that brief, structured, group-based, and task-shared interventions can produce measurable psychological gains for women whose suffering is linked to violence, poverty, and disrupted social environments. Problem Management Plus was specifically positioned for such contexts through its focus on stress management, problem solving, behavioral activation, and social support. In refugee settings, this trajectory continued with a pilot randomized controlled trial of peer-provided PM+ for adult Syrian refugees and with evidence showing that Self-Help Plus reduced psychological distress among South Sudanese female refugees in Uganda. Another important addition came through the Nguvu feasibility trial among Congolese refugee women in Tanzania, where an integrated violence- and mental-health-focused intervention addressed both intimate partner violence and psychological distress (Topol, 2019). Taken together, these studies show several recurring features: interventions are increasingly brief, manualized, and scalable; delivery often relies on lay or peer providers; female participants frequently benefit when sessions are safe, structured, and socially supportive; and mental health outcomes are frequently measured alongside functioning and exposure to violence. For a study on displaced women and SGBV survivors, this body of work supports an analytical focus on intervention participation, quality, trust, and barriers to utilization because those features repeatedly appear in the literature as important conditions shaping psychosocial change (Tol et al., 2020).

Another important feature of the literature is its recognition that intervention success in humanitarian settings depends on delivery conditions as much as on therapeutic content. A systematic review and meta-analysis of adult mental health and psychosocial support programs in humanitarian emergencies found evidence of benefit while also emphasizing the heterogeneity of interventions, outcomes, and implementation settings. A related review of interventions for women and children in conflict settings similarly showed that the field includes wide variation in provider type, delivery modality, and intervention scope, which makes close attention to context indispensable (Papini et al., 2018). A systematic review of psychosocial interventions for adult refugees and asylum seekers noted that the evidence base contains a strong concentration of trauma-focused modalities, while culturally adapted, group-based, and socially oriented interventions remain less evenly represented. Another review showed that psychosocial interventions are generally acceptable and effective for asylum seekers and refugees, yet the same evidence also reflected the complexity of comparing interventions that differ in format, population, and implementation intensity. In studies centered on women survivors of sexual violence, local stigma, humiliation, and disrupted social ties repeatedly appear as forces that shape access, retention, and recovery (Galatzer-Levy et al., 2017; Hall et al., 2014; Rahman et al., 2019). Community-based sociotherapy research in Rwanda also highlighted the value of socially embedded approaches for collective trauma and psychosocial wellbeing, which is useful for understanding why individual symptom reduction alone may not capture the full meaning of improvement among displaced women. For SGBV survivors, privacy, empathy, cultural sensitivity, non-judgmental care, and provider trustworthiness are not cosmetic features of service delivery; they are part of the mechanism by which women remain engaged in care and translate intervention experiences into reduced distress. This is why the present topic calls for conceptualizing psychosocial intervention effectiveness as a relational and contextual process (Tol, Patel, et al., 2011). Women who live in displacement settings often evaluate services through questions of safety, confidentiality, and social legitimacy, and these practical judgments are directly tied to participation patterns and reported outcomes. The literature therefore supports studying psychosocial interventions not merely as clinical packages, but as social encounters embedded in gendered humanitarian environments (Torous et al., 2018).

Across the literature from 2005 to 2021, a clear scholarly trajectory is visible: the field moved from documenting prevalence and risk among displaced populations toward identifying scalable interventions and context-sensitive models of care, while still leaving room for study designs that connect intervention characteristics to distress reduction among women exposed to SGBV. Meta-analytic work established the burden of mental disorder among refugees and internally displaced persons and the central role of post-displacement stressors (Rahman et al., 2019). Conceptual work then clarified that psychosocial recovery depends on safety, roles, social bonds, justice, and meaning, not solely on symptom remission (Tribe et al., 2017). Intervention research subsequently showed that cognitive processing therapy, common elements approaches, Problem Management Plus, Self-Help Plus, and integrated violence-plus-mental-health models can reduce distress and improve functioning among conflict-affected women, refugees, and survivors of systematic violence (Blease et al., 2019; Juravle et al., 2020). Reviews published within the same period repeatedly described a need for careful contextualization, stronger attention to women and girls in conflict settings, and closer examination of how intervention delivery conditions shape outcomes. For your study title, this body of evidence provides a strong scholarly base for examining displaced women and SGBV survivors through variables such as intervention accessibility, intervention quality, participation frequency, safe-service trust, and barriers to support utilization (Schultebrucks et al., 2020; Silove, 2013). The literature already shows that these dimensions matter; what it has not treated in a single integrated way is the quantitative association between such intervention-related factors and levels of distress within a case-study population of displaced women and SGBV survivors. That gap is especially important because this population's psychosocial reality is shaped by trauma exposure, social stigma, insecure living conditions, and patterns of service engagement all at once. Framing the introduction around these linked strands of evidence allows the study to enter the literature from a clearly grounded position: one that is international in significance, gender-specific in focus, psychosocial in scope, and evidence-based

in its orientation to intervention assessment (Wiens et al., 2019).

The background of this study is rooted in the growing humanitarian concern surrounding the psychological and social suffering experienced by displaced women and survivors of sexual and gender-based violence (SGBV) across conflict-affected and crisis-prone settings. Forced displacement often removes women from familiar homes, support systems, economic stability, and protective community structures, placing them in conditions of uncertainty, insecurity, and dependence. At the same time, many displaced women face heightened exposure to violence, exploitation, coercion, and stigma before, during, and after displacement (de Graaff et al., 2020). These overlapping hardships frequently produce deep psychosocial distress expressed through fear, anxiety, sadness, emotional instability, social withdrawal, loss of trust, reduced self-worth, and difficulty coping with daily life. For survivors of SGBV, the burden is often even more severe because the experience of violence may be accompanied by shame, silence, community rejection, family breakdown, and barriers to seeking help (Dawson et al., 2015; Steel et al., 2009; Tol, Barbu, et al., 2011). In humanitarian environments, psychosocial interventions have increasingly been introduced as structured support mechanisms intended to reduce emotional suffering, strengthen coping capacity, improve social functioning, and restore a sense of dignity and safety among affected women (Fazel et al., 2005). Such interventions may include counseling, support groups, trauma-informed care, peer support, case management, and other community-based services designed to address both psychological and social dimensions of distress. The relevance of this study emerges from the need to understand whether these interventions are actually effective in reducing distress among displaced women and SGBV survivors within real-life case settings. Many programs are implemented in crisis contexts, yet the outcomes may differ depending on their accessibility, quality, frequency, cultural appropriateness, privacy, and the level of trust women place in service providers. A focused examination of evidence-based psychosocial interventions is therefore important for identifying which aspects of support are most meaningful for recovery and emotional stabilization. This study is also grounded in the recognition that distress among displaced women is not shaped by a single event, but by a complex interaction of violence exposure, displacement conditions, social stigma, disrupted livelihoods, and limited-service access. Against this background, the present research seeks to provide a structured quantitative assessment of how psychosocial interventions relate to distress reduction among displaced women and SGBV survivors, making the study relevant to humanitarian programming, gender-sensitive protection efforts, and mental health support systems (Dawson et al., 2015).

The objective of this study is to provide a clear and structured quantitative examination of how evidence-based psychosocial interventions contribute to the reduction of distress among displaced women and survivors of sexual and gender-based violence within a defined case-study context. More specifically, the study aims to assess the psychosocial condition of displaced women and SGBV survivors by identifying the extent and pattern of distress experienced in relation to their displacement realities, trauma exposure, and social vulnerability. It also seeks to examine the main features of psychosocial interventions available to this population, including their accessibility, perceived quality, frequency of participation, and the degree to which they are delivered in a safe, confidential, and survivor-centered manner. A further objective is to analyze whether these intervention-related dimensions are significantly associated with reductions in distress and improvements in psychosocial wellbeing. In doing so, the study intends to move beyond general descriptions of support services and instead measure how concrete elements of intervention delivery relate to emotional stabilization, coping ability, trust restoration, and perceived recovery among the target population. Another objective is to identify the barriers that limit psychosocial support utilization, such as stigma, fear of disclosure, cultural constraints, lack of information, insecurity, and service inaccessibility, and to determine how these barriers may weaken the effectiveness of existing interventions. The study also aims to compare patterns across relevant case-based categories, such as differences in intervention exposure, trauma experiences, or displacement conditions, so that the analysis reflects the diversity of women lived experiences rather than treating all respondents as identical. At the final level, the objective is to generate evidence that can support the evaluation of psychosocial programming for displaced women and SGBV survivors by linking measurable intervention factors to measurable distress outcomes. Through this objective-based approach, the study establishes a coherent analytical

path for testing hypotheses, meeting research questions, and producing findings that are directly aligned with the core purpose of understanding how and under what conditions psychosocial interventions reduce distress in vulnerable displaced female populations.

LITERATURE REVIEW

The literature review for this study is grounded in the understanding that psychosocial distress among displaced women and survivors of sexual and gender-based violence emerges from a complex intersection of forced displacement, trauma exposure, social disruption, insecurity, stigma, and limited access to supportive services. Existing scholarship has shown that women in humanitarian settings often experience emotional suffering that extends beyond immediate trauma symptoms and includes fear, shame, withdrawal, mistrust, social isolation, and reduced functioning in daily life. Within this broader context, psychosocial interventions have been increasingly recognized as important support mechanisms aimed at reducing distress, strengthening coping capacity, restoring emotional stability, and improving social wellbeing among populations affected by conflict and displacement. The literature on

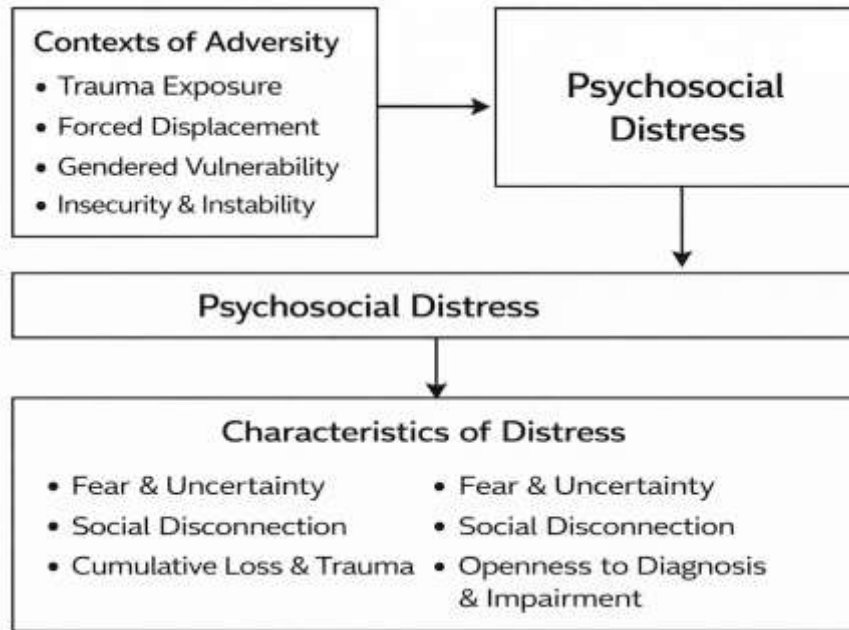
these subject spans several connected themes, including the nature of psychosocial distress in displaced populations, the specific vulnerabilities of women who have survived sexual and gender-based violence, the design and implementation of evidence-based psychosocial interventions in low-resource and crisis settings, and the theoretical perspectives used to explain recovery, resilience, trust, and survivor-centered care. A strong review of the literature is essential for this study because it helps position the research within the wider body of knowledge while also identifying the conceptual and empirical gaps that justify the present investigation. In this case, the literature review does not serve only as a summary of past studies; it provides the foundation for defining the study variables, shaping the theoretical and conceptual frameworks, and clarifying why intervention accessibility, quality, participation frequency, service trust, and barriers to utilization are relevant predictors of distress reduction. It also allows the study to examine how previous research has treated displaced women and SGBV survivors, whether these groups have been analyzed together or separately, and how intervention outcomes have been measured across different humanitarian contexts. Through this process, the literature review creates the academic basis for the study's research questions, hypotheses, and methodology by connecting existing evidence with the present research focus. As a result, this chapter is designed to move from broad conceptual understanding toward a more precise synthesis of theory, empirical findings, and analytical gaps relevant to evidence-based psychosocial interventions for reducing distress among displaced women and SGBV survivors.

Psychosocial Distress Among Displaced Women and SGBV Survivors

Psychosocial distress among displaced women and survivors of sexual and gender-based violence is best understood as a layered condition produced by trauma exposure, displacement-related insecurity, gendered vulnerability, and the continuing strain of social and material instability. The literature increasingly shows that women in forced migration settings do not experience distress only as a reaction to one violent event; rather, their suffering is often formed through repeated encounters with fear, uncertainty, loss, and social disconnection. A systematic review focused specifically on refugee women with trauma histories found that post-traumatic stress disorder was especially salient in this population and that sexual violence was repeatedly linked with elevated psychological risk, reinforcing the view that gendered trauma is central to women's mental health burden in refugee contexts (Vallejo-Martín et al., 2021). This pattern is consistent with broader work on sexual violence among refugee populations, where prevalence estimates varied substantially across settings but consistently pointed to sexual violence as a major threat during forced migration and asylum trajectories, especially for women and girls exposed to coercion, exploitation, and unsafe living arrangements (Araujo et al., 2019). The significance of these findings lies in the fact that psychosocial distress is not limited to diagnosable psychiatric symptoms; it also includes fearfulness, mistrust, social withdrawal, diminished coping ability, emotional dysregulation, and impaired everyday functioning. For displaced women, these conditions are further intensified by the erosion of ordinary support systems such as family protection, livelihood security, and trusted community networks. The literature therefore frames psychosocial distress as both an internal and contextual condition, shaped by what women have endured and by the environment in which they are trying to survive. In this sense, displaced women and SGBV survivors

represent a group whose psychosocial burden is tied to cumulative adversity rather than isolated trauma, making their distress especially complex, persistent, and socially embedded (Vallejo-Martín et al., 2021). This complexity gives strong justification for examining distress in a dedicated and gender-sensitive way within the present study.

Figure 2: Model Of Psychosocial Distress in Displaced Women and Sgbv Survivors



The severity of psychosocial distress among displaced women becomes even more visible when studies examine women classified as especially vulnerable within resettlement and post-displacement systems. Research on recently resettled refugee women-at-risk in Australia showed strikingly high levels of psychiatric symptoms, including trauma, anxiety, depression, and somatization, while also demonstrating that traumatic events and post-migration living difficulties were important predictors of poorer mental health outcomes (Khaled, 2021; Schweitzer et al., 2018). This is important because it shows that women’s distress is shaped not only by pre-migration violence but also by the pressures that continue after relocation, such as instability, parenting burden, language barriers, insecure social roles, and the absence of dependable protection. A later longitudinal follow-up with refugee women-at-risk found that psychological distress remained persistent over time, with trauma exposure, post-migration problems, loss, and lack of trust continuing to influence women’s symptom burden even after resettlement had begun (Manam & Ashfaq, 2022; Vromans et al., 2020). These findings are highly relevant to the current research because they demonstrate that psychosocial distress among displaced women can remain entrenched when social recovery does not keep pace with physical relocation. The literature therefore challenges any narrow assumption that movement to a place of refuge automatically produces emotional safety or psychological improvement. For many women, distress is maintained by unresolved loss, disrupted identity, uncertain belonging, and fragile interpersonal trust. This becomes particularly serious for women who have also survived sexual and gender-based violence, because their help-seeking behavior may be constrained by shame, silence, and fear of negative social responses. The evidence on women-at-risk thus contributes an important insight for the present study: psychosocial distress should be analyzed as a sustained condition influenced by both trauma history and the quality of the social environment in which displaced women live after violence and displacement have occurred. That insight supports a case-based investigation of distress reduction rather than a simple description of distress prevalence alone (Schweitzer et al., 2018; Binte & Sazzadul, 2022).

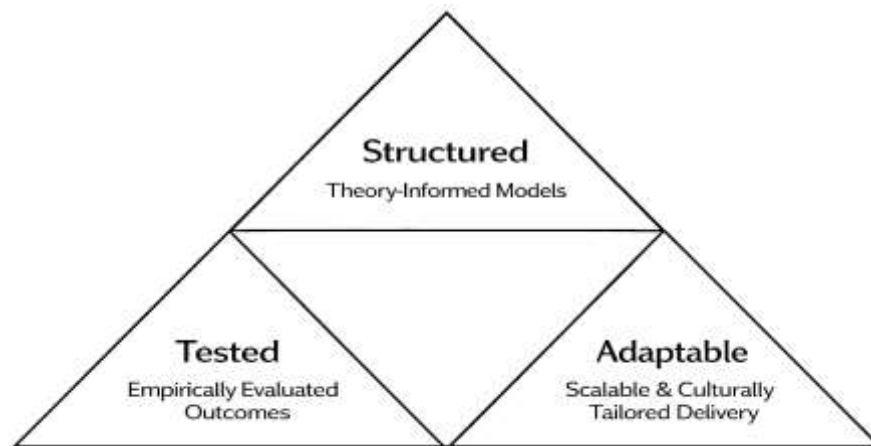
A related strand of scholarship shows that displaced women's psychosocial distress is strongly intertwined with exposure to violence in unstable living environments, where abuse, insecurity, and social vulnerability often continue after displacement itself. Evidence from internally displaced women in post-earthquake Haiti found high levels of violence and abuse both before and after displacement and showed that abused women reported significantly greater mental and physical health problems than non-abused women, illustrating how ongoing violence intensifies distress within already fragile humanitarian settings (Albert & Rashedul, 2023; Campbell et al., 2016). This type of finding is especially important for the present study because it demonstrates that displaced women's psychological suffering cannot be separated from the structural and interpersonal conditions surrounding them. When women remain exposed to abuse, crowding, weak social protection, and limited trust in community response, psychosocial distress becomes harder to relieve and more likely to affect daily functioning, safety, and willingness to disclose harm. The literature also suggests that SGBV survivors may carry a distinct psychosocial profile characterized by heightened fear, stigma, emotional pain, loss of confidence, and difficulty engaging with others, all of which can undermine recovery when support systems are inadequate or unsafe. The systematic review evidence on refugee women's trauma histories strengthens this interpretation by showing that gender-specific forms of violence are deeply connected to persistent post-traumatic symptomatology, while prevalence research on sexual violence among refugees reveals that these exposures are not marginal occurrences but recurring features of forced migration environments (Araujo et al., 2019; Onyinyechi, 2023). Taken together, these studies establish that psychosocial distress among displaced women and SGBV survivors is not a secondary issue within humanitarian response. It is a central condition affecting emotional stability, social participation, coping, and survival. This body of literature therefore provides the conceptual basis for the present study's focus on distress reduction, since understanding the depth and persistence of psychosocial suffering is necessary before the contribution of evidence-based psychosocial interventions can be properly assessed (Istiaq & Binte, 2023; Schweitzer et al., 2018).

Evidence-Based Psychosocial Interventions in Humanitarian Settings

Evidence-based psychosocial interventions in humanitarian settings refer to structured, theory-informed, and empirically tested approaches designed to reduce psychological distress, improve functioning, and strengthen coping among populations exposed to war, persecution, forced migration, and chronic adversity. In refugee and asylum contexts, the literature shows that interventions are most often developed around trauma-focused, cognitive-behavioral, transdiagnostic, or exposure-based models, and that their "evidence-based" status depends on manualization, measurable outcomes, and evaluation through controlled trials or systematic review methods. One important body of evidence comes from reviews focused on post-traumatic stress treatment among refugees and asylum seekers. A systematic review and meta-analysis found that psychosocial interventions overall reduced PTSD symptoms in displaced adults resettled in high-income countries, with narrative exposure therapy emerging as one of the most consistently supported approaches, even though the overall evidence base remained limited in size and methodological strength (Robel & Aminul, 2023; Nosè et al., 2017). A second meta-analysis likewise concluded that trauma-focused psychological interventions were supported for refugee and asylum-seeking adults with PTSD, especially EMDR and narrative exposure therapy, while also noting the smaller amount of evidence for non-trauma-focused or group-based models (Sazzadul, 2023; Thompson et al., 2018). These findings are important for the present study because they show that humanitarian psychosocial programming is not simply a matter of offering supportive contact; rather, the field has increasingly moved toward interventions whose components, delivery procedures, and outcomes can be tested in a disciplined way. In this sense, evidence-based psychosocial care is linked to replicability, measurable symptom change, and culturally workable implementation rather than general goodwill alone. The literature also makes clear that displaced populations often present with co-occurring depression, anxiety, post-traumatic stress, grief, functional impairment, and chronic stress, which means interventions that can address multiple domains simultaneously are especially valuable in crisis settings where specialist resources are scarce and service demand is high (Thompson et al., 2018). This broader shift toward structured, tested, and adaptable psychosocial care provides the conceptual basis for examining how intervention quality and delivery shape outcomes among displaced women and SGBV survivors in the present research.

Randomized intervention studies provide further insight into how evidence-based psychosocial interventions operate in refugee settings and why they matter. A randomized controlled trial among Syrian refugees in a camp on the Turkish–Syrian border found that eye movement desensitization and reprocessing produced significantly greater reductions in PTSD and depression symptoms than a wait-list condition, indicating that even in conditions of ongoing displacement and insecurity, structured trauma-focused care can yield measurable clinical gains (Acarturk et al., 2016). Another line of work has argued that refugee distress is not explained only by trauma memory but also by disruptions in safety, attachment, justice, identity, and meaning, which has informed the development of interventions that are tailored more directly to displacement-related stress. In Malaysia, a randomized controlled trial comparing Integrative Adapt Therapy with brief cognitive behavioral therapy among Rohingya, Chin, and Kachin refugees showed that the integrative approach achieved greater reductions in common mental disorder symptoms and adaptive stress indicators, while also increasing resilience scores, suggesting that a refugee-specific therapeutic model may outperform more generic short-form CBT under some conditions (Tay et al., 2020).

Figure 3: Framework Of Evidence-Based Psychosocial Interventions In Humanitarian Contexts



What makes these studies especially relevant is that they demonstrate two important characteristics of the evidence base. First, intervention effectiveness can be established quantitatively in refugee populations living in unstable and resource-limited environments. Second, different interventions may work through different mechanisms: some primarily target trauma symptoms through focused exposure and reprocessing, while others address a wider ecology of stress, adaptation, and psychosocial disruption. This distinction matters for the current study because displaced women and SGBV survivors often experience distress through both traumatic memory and ongoing relational insecurity, stigma, and loss of social role. Evidence-based psychosocial interventions therefore need to be understood not only by their therapeutic label but also by the specific dimensions of suffering they are designed to address. The literature thus supports a nuanced reading of intervention effectiveness, where symptom reduction, resilience, and adaptive functioning are all relevant outcomes in humanitarian mental health research (Akhtar et al., 2021). A further development in the field is the rise of scalable and culturally adaptable interventions that can be delivered by non-specialists, peers, or trained lay facilitators, which is especially important in humanitarian settings where specialized mental health workforces are often insufficient. The movement toward scalability reflects recognition that displaced populations frequently outnumber available clinicians and that short, structured interventions are often the only realistic way to extend care within camps and other fragile service environments. A 2021 feasibility trial of a brief scalable psychological intervention for Syrian refugee adolescents in Jordan showed that group-based delivery was safe, culturally acceptable, and operationally feasible, supporting the readiness of such models for larger effectiveness testing in humanitarian contexts (Wright et al., 2021). In parallel, a systematic review and meta-analysis of

narrative exposure therapy found that this intervention produced medium to large effects on trauma-related outcomes for refugees and asylum seekers, while also emphasizing the importance of cultural adaptation in language, context, and delivery if interventions are to remain acceptable and meaningful across different displaced populations (Wright et al., 2021). Together, these studies highlight two core features of evidence-based psychosocial interventions in humanitarian settings: they must be scalable enough to reach large numbers of affected people, and they must be adaptable enough to fit the social and cultural realities of those receiving care. This is highly relevant to the present study because displaced women and SGBV survivors may judge interventions not only by whether they reduce distress, but also by whether they feel safe, understandable, respectful, and compatible with their lived experience. Evidence-based practice in humanitarian mental health therefore includes both efficacy and contextual fit. The literature increasingly treats implementation qualities such as cultural adaptation, delivery format, and service acceptability as part of intervention success rather than as secondary concerns. For that reason, any serious evaluation of psychosocial interventions for displaced women and SGBV survivors must consider access, trust, participation, and quality of delivery alongside emotional outcomes, since these are the conditions through which evidence-based care becomes effective in real-world humanitarian environments.

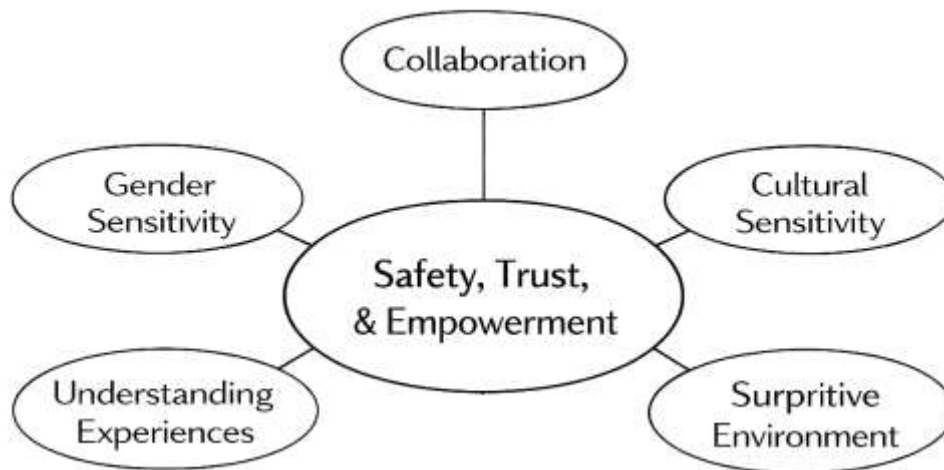
Theoretical Framework: Trauma-Informed Care Theory

Trauma-Informed Care Theory provides the most suitable theoretical foundation for this study because it explains why psychosocial support for displaced women and survivors of sexual and gender-based violence must be organized around safety, trust, collaboration, empowerment, and sensitivity to cultural and gendered experiences rather than around symptom treatment alone. In trauma-informed scholarship, trauma is understood not only as a past event but as a condition that shapes how a person interprets risk, relationships, authority, disclosure, and help-seeking within present service environments. For women exposed to displacement and SGBV, this perspective is especially relevant because intervention settings can either support recovery or unintentionally reproduce fear, silence, and retraumatization. Machtinger et al. (2015) argued that trauma-informed primary care for women should move from a narrow treatment orientation to a healing orientation, emphasizing that trauma affects emotional regulation, physical health, engagement with care, and willingness to trust providers. Raja et al. (2015) similarly described trauma-informed care as a conceptual and operational framework that translates awareness of trauma into everyday clinical interactions through universal trauma precautions and trauma-specific responses. Together, these contributions are central to the present study because they support the view that psychosocial interventions should not be judged only by whether they exist, but by whether women experience them as safe, respectful, predictable, and non-threatening. This aligns closely with the realities of displaced women and SGBV survivors, whose distress is often intensified when institutions feel controlling, dismissive, culturally distant, or unsafe. Under Trauma-Informed Care Theory, service quality therefore includes relational qualities such as confidentiality, empathy, transparency, voice, and emotional safety. This theoretical lens fits the current research because the study examines distress reduction not as a purely internal clinical outcome, but as a result influenced by intervention accessibility, perceived quality, trust in service delivery, and barriers that shape women's engagement with care. In this way, Trauma-Informed Care Theory offers a direct bridge between the lived conditions of vulnerable women and the measurable service factors examined in the present study (Machtinger et al., 2015; Raja et al., 2015).

A major strength of Trauma-Informed Care Theory is that it expands the understanding of effective intervention beyond the management of distress symptoms and places equal emphasis on context, identity, and the social meaning of care. This is highly relevant for displaced women and SGBV survivors because trauma is frequently embedded in power imbalance, bodily violation, forced movement, family separation, stigma, and institutional dependency. Ranjbar et al. (2020) showed that trauma-informed care becomes more responsive when it is practiced with cultural humility, since traumatic experiences are interpreted through social background, collective history, and local meanings of suffering, trust, and dignity. That argument is especially useful for this study because displaced women are not a culturally uniform population, and their willingness to participate in psychosocial interventions may depend on whether services acknowledge language, gender norms, migration history, and community-based meanings of violence and healing. This same concern appears

in refugee-specific literature. Im and Swan (2021) found that culturally responsive trauma-informed care in refugee resettlement requires more than simple trauma awareness; it requires providers and systems to understand how refugee trauma, acculturation pressures, and fragmented services interact to shape mental health and psychosocial wellbeing. Their work highlights that trauma-informed systems should connect refugee-serving agencies, psychosocial support programs, and mainstream mental health services in ways that reduce fragmentation and improve trust. For the current research, this insight is crucial because displaced women and SGBV survivors often encounter multiple barriers at once, including fear of disclosure, practical service inaccessibility, and uncertainty about whether providers will respond respectfully. Trauma-Informed Care Theory therefore helps explain why safe-service trust, survivor-centered care, and cultural responsiveness are not secondary concerns but core predictors of intervention effectiveness. The theory also supports the inclusion of barriers to support utilization as a serious analytical variable, because women may remain distressed not only because of trauma severity, but because available services are not sufficiently accessible, coordinated, or culturally safe. Accordingly, this theoretical framework justifies the study’s focus on service experience as part of the causal pathway leading to distress reduction (Im & Swan, 2020; Ranjbar et al., 2020).

Figure 4: Core Principles of Trauma-Informed Care Theory



Trauma-Informed Care Theory is also valuable for this study because it can be translated into measurable constructs and tested statistically within a quantitative design. Han et al. (2021) showed in their systematic review that trauma-informed interventions are commonly evaluated through outcomes such as PTSD, depression, anxiety, interpersonal functioning, and emotional regulation, while implementation quality remains an important determinant of whether such interventions achieve beneficial effects. This reinforces the logic of the current research design, where the theoretical principles of trauma-informed care are operationalized into variables such as intervention accessibility, intervention quality, participation frequency, safe-service trust, and barriers to psychosocial support utilization. In practical terms, the theory guides the construction of a regression model in which distress reduction is treated as the dependent variable and trauma-informed service dimensions are treated as predictors. The core analytical model for this study can therefore be expressed in LaTeX equation format as:

$$DR = \beta_0 + \beta_1 ACC + \beta_2 QUAL + \beta_3 FREQ + \beta_4 TRUST - \beta_5 BARR + \varepsilon$$

Where:

- DR* = Distress Reduction
- ACC* = Accessibility of Psychosocial Interventions
- QUAL* = Perceived Quality of Psychosocial Interventions
- FREQ* = Frequency of Participation

TRUST = Safe-Service Trust and Survivor-Centered Care

BARR = Barriers to Psychosocial Support Utilization

β_0 = Intercept

$\beta_1, \beta_2, \beta_3, \beta_4, \beta_5$ = Regression Coefficients

ε = Error Term

This formula is the best fit for the whole study because it directly mirrors the hypotheses and allows the theory to be examined empirically through the relative influence of service-related factors on psychosocial outcomes. Within this structure, Trauma-Informed Care Theory is not used only as background philosophy; it becomes the organizing logic for variable selection, questionnaire development, hypothesis formulation, and interpretation of findings. Its application is especially appropriate because it recognizes that reduced distress among displaced women and SGBV survivors depends not only on receiving support, but on receiving support in ways that are safe, respectful, empowering, culturally responsive, and practically reachable (Han et al., 2021).

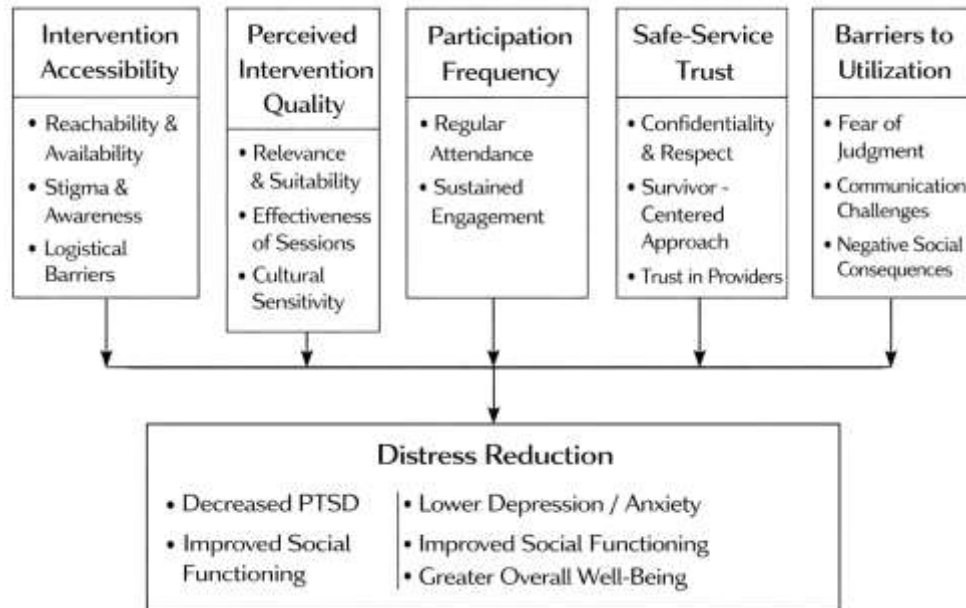
Conceptual Framework

The conceptual framework for this study is based on the assumption that distress reduction among displaced women and survivors of sexual and gender-based violence is not produced by psychosocial intervention exposure alone, but by the combined influence of service accessibility, perceived intervention quality, continuity of participation, relational trust, and barriers to utilization. This perspective is grounded in literature showing that the mental health burden of displaced women is shaped by both traumatic exposure and the social conditions surrounding resettlement, care access, and daily survival. Research on refugee women's socio-cultural and health experiences has shown that emotional wellbeing is closely linked to isolation, disrupted support systems, language constraints, social exclusion, and limited familiarity with host-country services, indicating that psychosocial recovery depends on more than the internal processing of trauma alone (Shishehgar et al., 2017). A comparative analysis of refugees and immigrants in the United States also demonstrated that post-migration stressors such as discrimination, acculturative stress, and family conflict significantly increase risk for distress and mental disorder, reinforcing the idea that psychosocial outcomes are embedded within the wider stress environment in which displaced women live (Sangalang et al., 2019). On that basis, the present conceptual framework defines distress reduction as the dependent variable and treats intervention accessibility, intervention quality, participation frequency, safe-service trust, and barriers to service utilization as the principal independent variables. The framework assumes that when psychosocial support is reachable, relevant, regular, confidential, and delivered in a way that women perceive as respectful and survivor-centered, distress is more likely to decrease. At the same time, when support is limited by stigma, poor communication, logistical difficulty, fear of disclosure, or mistrust of providers, the beneficial effect of psychosocial intervention is weakened. This makes the conceptual framework especially suitable for the current study because it captures the interaction between intervention design and women lived realities in displacement settings, rather than treating support services as neutral inputs with uniform effects across all survivors.

A second core element of the conceptual framework is the recognition that psychosocial intervention effectiveness is filtered through women's help-seeking pathways and their subjective experience of care. In refugee and immigrant women, the decision to seek and continue care is often shaped by social stigma, cultural expectations, fear of judgment, prior exposure to violence, and uncertainty about whether available services are emotionally safe or socially acceptable. This has important implications for a study focused on displaced women and SGBV survivors, because the existence of support services does not automatically ensure meaningful participation or distress reduction. An exploratory study of immigrant and refugee women's mental health experiences found that coping and help-seeking were strongly influenced by accessibility, suitability of programs, and the supportiveness of surrounding social networks, which suggests that service utilization is part of the psychosocial process rather than a separate administrative issue (Donnelly et al., 2011). Similarly, research on West African refugee women in Australia found that shame, fear of family or community reaction, fear of being judged by providers, and logistical obstacles were significant barriers to accessing health care, illustrating how emotional and structural barriers can suppress the use of services even when women are in need of support (Drummond et al., 2011). The conceptual framework of the present study therefore positions

barriers to psychosocial support utilization as a negative predictor and safe-service trust and survivor-centered care as a positive predictor of distress reduction. These variables are included because women who perceive services as unsafe, stigmatizing, or difficult to access may attend irregularly, disclose less, or withdraw entirely from support processes. By contrast, women who feel respected, heard, protected, and understood are more likely to engage consistently and experience psychosocial benefit. This logic also supports the inclusion of participation frequency as a distinct variable, since regular engagement may strengthen the continuity of therapeutic contact, reinforce coping practices, and increase the cumulative effect of intervention exposure across time.

Figure 5: Determinants Of Distress Reduction in Displaced Women and Sgbv Survivors



The full conceptual relationship guiding this study can therefore be represented through a regression-based model in which distress reduction is predicted by intervention-related and service-experience variables. In LaTeX form, the model can be expressed as:

$$DR = \beta_0 + \beta_1 ACC + \beta_2 QUAL + \beta_3 FREQ + \beta_4 TRUST - \beta_5 BARR + \varepsilon$$

where *DR* denotes distress reduction, *ACC* denotes accessibility of psychosocial interventions, *QUAL* denotes perceived intervention quality, *FREQ* denotes frequency of participation, *TRUST* denotes safe-service trust and survivor-centered care, *BARR* denotes barriers to psychosocial support utilization, β_0 is the intercept, β_1 to β_5 are regression coefficients, and ε is the error term. This formula is appropriate for the whole study because it converts the conceptual assumptions into measurable relationships that can be tested statistically through correlation and regression analysis. The framework also reflects prior evidence that violence exposure and psychosocial distress among refugee women are closely related to relational insecurity and partner abuse. For example, a study of Somali refugee women found that partner violence and acculturation-related strain were significantly associated with psychological distress, supporting the position that women’s emotional outcomes are influenced by both personal trauma and the relational context in which they live and seek care (Nilsson et al., 2008). In the current study, that insight strengthens the decision to connect intervention variables with broader experiential variables such as trust and barriers, rather than limiting the model to simple service attendance. Overall, this conceptual framework integrates structural, interpersonal, and programmatic dimensions into one analytical model, allowing the study to examine how evidence-based psychosocial interventions operate in practice for displaced women and SGBV survivors whose recovery is shaped by trauma, stigma, social conditions, and the quality-of-service encounters.

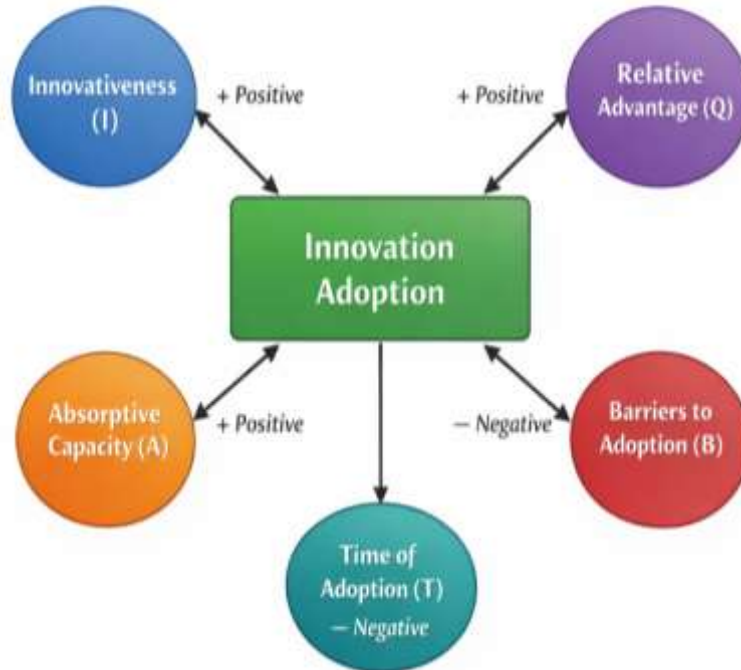
Empirical Review of Previous Studies

Empirical studies conducted between 2005 and 2021 show that psychosocial interventions in refugee and humanitarian settings have gradually shifted from broad supportive programming toward more structured, measurable, and context-sensitive models of care. One of the earlier intervention trials with direct relevance to crisis-affected displaced populations was the pilot randomized controlled trial on Syrian refugees living in a camp setting, which found that eye movement desensitization and reprocessing reduced posttraumatic stress and depressive symptoms more effectively than a wait-list control. That study is important because it demonstrated that an evidence-based trauma treatment could be delivered even in a refugee camp environment characterized by instability and constrained resources, thereby strengthening the argument that psychological interventions can retain measurable value under humanitarian conditions rather than only in conventional clinical settings (Acarturk et al., 2015). Another notable empirical contribution came from the culturally adapted Health Realization Community Coping Intervention for Somali refugee women after resettlement. That three-arm comparison trial showed significant improvements in several coping domains, including distancing, seeking social support, and positive reappraisal, while also indicating improvement in depression symptom ratings. The significance of this study lies in its emphasis on women's coping resources and culturally meaningful delivery, suggesting that psychosocial gains are not limited to symptom reduction but may also emerge through stronger internal appraisal, social connection, and adaptive coping behavior (Robertson et al., 2019). Taken together, these studies show two closely related patterns that are directly relevant to the present research. First, psychosocial interventions can generate observable improvement in emotionally burdened refugee populations across both camp-based and post-resettlement settings. Second, intervention effectiveness appears to depend not only on treatment content but also on whether the intervention is shaped around the population's social reality, language needs, and culturally grounded modes of support. These findings are especially useful for the current study because displaced women and SGBV survivors often require intervention environments that are not only clinically responsive but also psychologically safe, relationally respectful, and sufficiently adapted to their lived circumstances. In empirical terms, these earlier studies provide evidence that both trauma-focused and coping-oriented interventions can influence distress-related outcomes when delivery is carefully aligned with population needs.

A second cluster of empirical studies expanded the intervention landscape by testing scalable and delivery-flexible models that respond to the practical barriers commonly faced by refugees and other displaced populations. One especially relevant example is the pilot study that combined in-person group work with a language-free mobile mental health application for Somali-Bantu and Nepali-Bhutanese adult refugees. This intervention significantly reduced traumatic stress, anxiety, depression, and somatic complaints while increasing the use of coping skills, highlighting the value of designing psychosocial support in ways that reduce language dependency and broaden access beyond conventional text-based therapeutic formats (Mazzulla et al., 2021). This is highly relevant to the current research because displaced women and SGBV survivors often experience barriers related to literacy, language, privacy, transport, and confidence in formal services. Another major empirical contribution was the multinational randomized controlled trial of Self-Help Plus among refugees and asylum seekers in Western Europe. That study found no prevention effect for mental disorders at six months, yet it did find significant short-term benefits immediately after the intervention, particularly for mental disorder frequency measured shortly after treatment delivery. The study is therefore important not because it offers a simple success narrative, but because it shows that intervention effects may be time-sensitive and that some scalable psychosocial approaches may generate immediate relief without automatically sustaining long-term gains unless follow-up supports are present (Purgato et al., 2021). These two studies enrich the empirical literature in a way that matters for the present thesis. They suggest that psychosocial intervention effectiveness should be interpreted along several dimensions at once: immediate versus sustained outcome, technological accessibility versus interpersonal delivery, and symptom relief versus coping enhancement. For displaced women and SGBV survivors, these distinctions are analytically significant because a service may be acceptable, accessible, and beneficial in the short term, while still requiring stronger relational continuity, survivor-centered trust, and repeated engagement to produce durable distress reduction. The empirical record therefore encourages

a more nuanced approach to intervention evaluation, one that does not equate program presence with program effectiveness and does not treat short-term symptom reduction as the only valid outcome of psychosocial care.

Figure 6: Empirical Framework Linking Psychosocial Intervention Factors To Distress Outcomes



A third empirical pattern appears in studies that examine interventions explicitly developed for refugee experiences and delivered in acute humanitarian contexts rather than only after crisis stabilization. A strong example is the naturalistic evaluation of Group Integrative Adapt Therapy with Rohingya refugees during the emergency phase of the mass humanitarian crisis in Cox’s Bazar, Bangladesh. That study is especially valuable because it moved beyond the idea that rigorous psychosocial evaluation must wait until a crisis settles. Instead, it showed that a structured group intervention tailored to refugee-specific psychosocial disruptions could be implemented during an emergency phase and could produce meaningful improvements in depression, PTSD, adaptive stress, and functioning outcomes over time (Tay et al., 2021). This study adds an important empirical dimension to the broader literature because it links intervention effectiveness to the social ecology of forced displacement, including disrupted attachments, compromised roles, threatened safety, and ongoing uncertainty. When synthesized with the other studies reviewed above, the evidence suggests that distress reduction among displaced populations follows a pattern that can be conceptually represented as

$$\Delta D = \alpha + \beta_1 I + \beta_2 Q + \beta_3 A + \beta_4 T - \beta_5 B + \varepsilon$$

where ΔD represents change in distress, I represents intervention exposure, Q represents perceived quality, A represents accessibility, T represents trust or therapeutic safety, and B represents barriers to utilization. This synthesis is consistent with the current study because the prior empirical record repeatedly shows that psychosocial outcomes are shaped not by a single intervention ingredient but by the interaction of treatment structure, cultural fit, continuity, delivery conditions, and social acceptability. The reviewed studies also reveal an important gap: although there is growing empirical evidence for interventions in refugee and humanitarian contexts, fewer studies isolate how accessibility, service quality, participation frequency, and trust jointly predict distress reduction specifically among displaced women and SGBV survivors within a single case-based quantitative model. For that reason, the present study extends the empirical conversation by taking the intervention-

related factors suggested by previous studies and testing them together in a focused analysis of women whose psychosocial burden is shaped by both displacement and gendered violence.

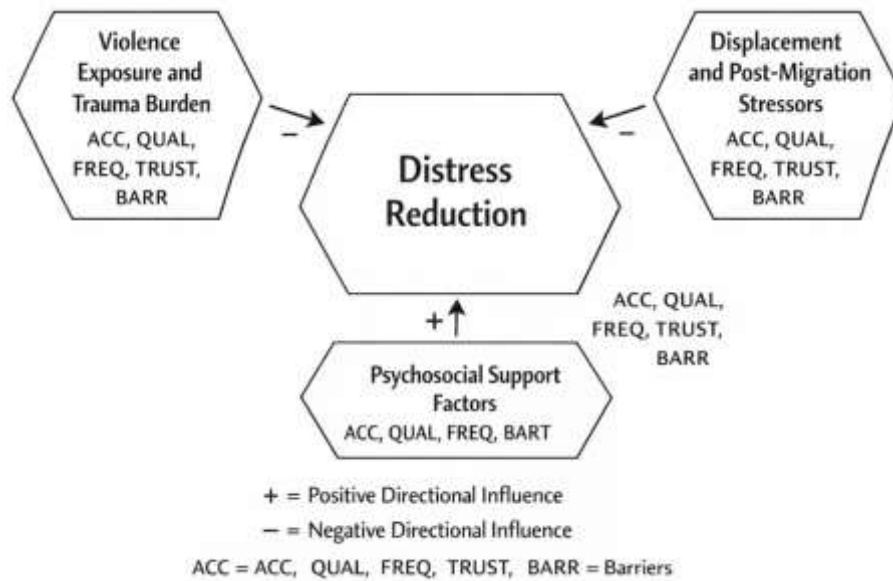
Research Gap and Literature Synthesis

The literature reviewed in the preceding sections establishes a strong foundation for understanding the psychological vulnerability of displaced women and survivors of sexual and gender-based violence, yet it also reveals an uneven pattern of evidence that leaves several important analytical gaps unresolved. A major strength of the existing scholarship is that it clearly demonstrates the multidimensional character of women's distress in forced migration settings. Refugee women's mental health is repeatedly shown to be shaped by violence exposure, disrupted social support, poverty, language barriers, stigma, weak institutional response, and difficulty navigating health systems, which means distress is embedded in both personal trauma and the social ecology of displacement (Ruiz et al., 2021). At the same time, recent qualitative and mixed-methods studies have deepened this understanding by showing that sexual and gender-based violence among refugee women operates along a continuum that stretches across public and private spaces and across different stages of displacement, with abuse, intimidation, coercion, child marriage, intimate partner violence, and sexual exploitation often intersecting in women's everyday lives (Roupetz et al., 2020). Research has also shown that mental health burdens among refugee women are strongly associated with different configurations of violence exposure, and that severe forms of gender-based violence correspond to especially serious distress profiles in camp-based and humanitarian settings (Hossain et al., 2021). In addition, work in Lebanon has highlighted how women engaged in psychosocial programming continue to experience strong links between gender-based violence and psychological distress, while also emphasizing the importance of coordinated, survivor-centered, and contextually sensitive services that respond to economic strain, family pressures, and broader environmental stressors. When synthesized together, these studies show that the field has moved well beyond a narrow trauma-only approach. The literature now recognizes that women's psychosocial suffering in displacement settings is cumulative, relational, and socially conditioned. Even so, the same body of work remains more descriptive than integrative in many places, because it often documents vulnerabilities, forms of violence, and broad service needs without fully testing the intervention-related mechanisms through which distress may actually be reduced for displaced women and SGBV survivors.

A second and more specific gap lies in how previous studies have treated psychosocial interventions and their outcomes. Although there is a growing body of research on refugee women's health, social support, violence exposure, and access to services, far fewer studies examine the combined influence of intervention accessibility, perceived quality, continuity of participation, safe-service trust, and barriers to utilization within one quantitative explanatory model. Much of the broader literature identifies these factors separately. For example, refugee women's health reviews emphasize the importance of communication, provider awareness, social support, and service access, but these reviews typically operate at the level of synthesis and thematic description rather than testing how those factors jointly predict mental health improvement in a single empirical design (Ruiz et al., 2021). Similarly, critical work on post-migration determinants of refugee mental health shows that housing, income insecurity, family separation, uncertainty, and discrimination are central to psychosocial wellbeing, while also pointing out that relatively few multimodal interventions have been evaluated in ways that convincingly connect these wider social determinants with intervention effectiveness. Studies on gender-based violence among refugee women provide another important insight: they illustrate that women's distress is inseparable from patterns of violence and coercion, yet they rarely move from documenting those realities to quantitatively modeling which aspects of psychosocial service delivery most strongly support recovery (Barada et al., 2021). As a result, the literature contains strong evidence about risk, vulnerability, and lived experience, but less integrated evidence about intervention process. This is a crucial limitation for the present topic because evidence-based psychosocial support should not be evaluated only by asking whether services are available. It should also be evaluated by asking whether women can access them consistently, whether they perceive them as high quality, whether they trust service providers enough to disclose and engage, and whether barriers such as stigma, fear, mobility restrictions, and uncertainty continue to weaken intervention impact. In this sense, the key research gap is not an absence of literature on distress or gender-based

violence, but an absence of sufficiently focused quantitative studies that connect intervention characteristics to distress reduction among displaced women and SGBV survivors in a coherent case-based framework (Hynie, 2018).

Figure 7: Synthesis Model of Psychosocial Intervention Determinants And Distress Reduction



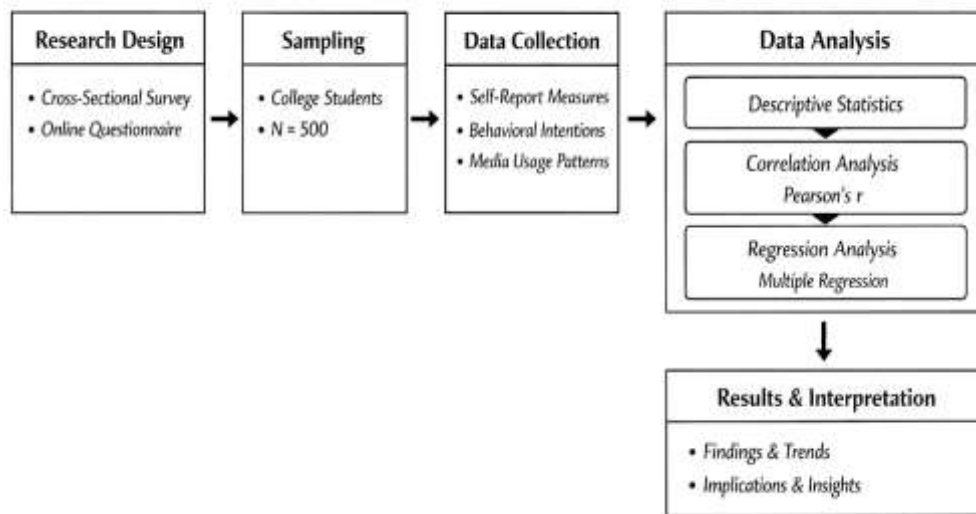
The present study is designed to respond directly to that gap through a literature-informed synthesis that treats psychosocial intervention effectiveness as a multidimensional relationship rather than a simple program outcome. The literature suggests that the psychosocial realities of displaced women are shaped by three overlapping domains: first, violence exposure and trauma burden; second, the displacement environment and post-migration stressors; and third, the quality and accessibility of available psychosocial support. What remains insufficiently addressed in previous studies is the empirical integration of these domains into a single explanatory structure that can test whether evidence-based psychosocial interventions are associated with reduced distress once service-related dimensions are properly specified. That is the point at which the current research makes its contribution. By focusing on accessibility, intervention quality, frequency of participation, safe-service trust and survivor-centered care, and barriers to psychosocial support utilization, the study converts the broad themes identified in the literature into measurable variables that can be examined through descriptive statistics, correlation analysis, and regression modeling. In conceptual terms, the literature synthesis behind this approach can be expressed as $DR = f(ACC, QUAL, FREQ, TRUST, -BARR)$, where distress reduction is treated as a function of positive service conditions and negatively affected by utilization barriers. This formula is not presented as a universal law, but as a compact representation of the evidence pattern emerging from the literature review: women’s psychosocial outcomes improve not simply because an intervention exists, but because it is reachable, acceptable, trusted, repeated, and delivered under conditions that minimize fear and exclusion. The final literature gap, therefore, lies in the need for a study that quantitatively tests that pattern among displaced women and SGBV survivors within a defined case-study setting. Such a study is necessary because the existing literature has already shown why these women are at risk and why support matters, yet it has not sufficiently clarified which specific intervention-related dimensions most strongly predict distress reduction when examined together in one analytical model grounded in women’s lived realities of displacement, violence, and psychosocial care (Ruiz et al., 2021).

METHOD

Research Design

This study has adopted a quantitative, cross-sectional, case-study-based research design in order to examine the effectiveness of evidence-based psychosocial interventions in reducing distress among displaced women and survivors of sexual and gender-based violence. A quantitative design has been selected because it has enabled the study to measure the major variables in numerical form and to test the proposed hypotheses through statistical procedures. The cross-sectional approach has been used because data have been collected from respondents at a single point in time, allowing the researcher to assess existing patterns of distress, intervention exposure, and psychosocial outcomes within the selected setting. In addition, the case-study-based orientation has provided contextual depth by focusing on a specific displacement-related environment in which women have experienced both psychosocial distress and intervention support. This design has therefore supported the use of descriptive statistics, correlation analysis, and regression modeling in a structured and logically consistent manner.

Figure 8: Research Methodology



Case Study Context

The case study context of this research has been defined as a displacement-affected setting in which displaced women and survivors of sexual and gender-based violence have had exposure to psychosocial support services delivered by humanitarian actors, social workers, community-based organizations, or protection-oriented institutions. This setting has been selected because it has represented the real-life environment in which violence exposure, displacement, emotional distress, and psychosocial intervention have interacted. The context has also been considered appropriate because it has allowed the researcher to examine not only the presence of psychosocial services but also the conditions under which such services have been accessed, trusted, and experienced by the target population. By using a specific case-study setting, the research has been grounded in practical realities rather than abstract assumptions. As a result, the contextual focus has strengthened the relevance of the findings by linking psychosocial intervention effectiveness to the lived experiences of women in displacement conditions.

Population and Unit of Analysis

The population of this study has consisted of displaced women and survivors of sexual and gender-based violence who have lived within the selected case-study setting and who have been eligible for, exposed to, or engaged with psychosocial intervention services. The study has focused specifically on this population because these women have faced heightened psychosocial vulnerability resulting from the combined effects of trauma exposure, displacement, insecurity, stigma, and disrupted support systems. The unit of analysis has been the individual respondent, since the research has aimed to

measure personal experiences, perceptions, and outcomes at the individual level. Each woman has therefore represented one analytical unit from which data on intervention accessibility, service quality, participation frequency, trust in service delivery, barriers to utilization, and distress reduction have been obtained. By defining the population and unit of analysis in this way, the study has ensured that the data have remained closely aligned with the research objectives, conceptual framework, and hypothesis-testing procedures.

Sampling Strategy

This study has used a sampling strategy based on purposive and convenience sampling techniques in order to identify respondents who have matched the specific characteristics required for the research. Purposive sampling has been applied because the study has targeted displaced women and survivors of sexual and gender-based violence who have had direct relevance to the research topic and who have been able to provide meaningful information about psychosocial interventions and distress reduction. At the same time, convenience sampling has been employed to improve access to respondents within the practical and ethical limitations of the humanitarian setting. This combined strategy has been considered appropriate because the target population has been specialized, vulnerable, and not easily reachable through probability methods in many displacement contexts. The sample size has been selected to ensure that enough responses have been obtained for descriptive and inferential statistical analysis. Through this strategy, the study has balanced feasibility, safety, relevance, and analytical usefulness in the participant selection process.

Data Collection Procedure

The data collection procedure has involved the administration of a structured questionnaire to eligible respondents within the selected case-study setting after appropriate ethical and procedural safeguards have been observed. Before data collection has begun, respondents have been informed about the purpose of the study, the voluntary nature of participation, and the protection of confidentiality and anonymity. Informed consent has been obtained from all participants prior to their involvement in the study. The questionnaire has then been distributed in a manner that has respected privacy, emotional sensitivity, and the vulnerability of women who have experienced displacement and sexual or gender-based violence. A trauma-sensitive approach has been followed throughout the process so that respondents have not been exposed to unnecessary emotional discomfort. Where needed, explanations have been provided to clarify questionnaire items without influencing responses. Through these procedures, the study has ensured that data have been collected systematically, ethically, and in a manner consistent with the dignity and safety of the respondents.

Instrument Design

The research instrument has been designed as a structured questionnaire based on the study objectives, conceptual framework, and hypotheses. The questionnaire has been developed to capture the major variables of the study, including demographic characteristics, case-context conditions, trauma exposure patterns, accessibility of psychosocial interventions, perceived quality of services, frequency of participation, safe-service trust and survivor-centered care, barriers to psychosocial support utilization, and distress reduction outcomes. A five-point Likert scale has been used for most of the attitudinal and perception-based items, where 1 has represented Strongly Disagree, 2 has represented Disagree, 3 has represented Neutral, 4 has represented Agree, and 5 has represented Strongly Agree. This format has been selected because it has allowed respondents to express different levels of agreement in a simple and measurable way. The questionnaire has been organized into clear sections so that the flow of items has remained logical, understandable, and aligned with the analytical needs of the study.

Pilot Testing

Pilot testing has been conducted before the main data collection phase in order to examine the clarity, relevance, structure, and sensitivity of the questionnaire items. A small group of respondents with characteristics similar to those of the main study population has been selected for this preliminary stage. The purpose of the pilot test has been to determine whether the wording of the items has been understandable, whether the sequence of questions has been logical, and whether any statements have been ambiguous, repetitive, or emotionally difficult for participants to answer. During this process, feedback has been gathered regarding the clarity of the response options and the overall length of the

questionnaire. Based on the observations made during pilot testing, necessary revisions have been introduced to improve the instrument. Items that have appeared unclear or overly sensitive have been refined in wording and structure. In this way, pilot testing has strengthened the overall suitability of the questionnaire for the main study.

Validity and Reliability

The validity and reliability of the instrument have been addressed to ensure that the data collection process has remained scientifically sound and consistent with the study objectives. Content validity has been established by ensuring that the questionnaire items have adequately covered all major variables of the study and have reflected the dimensions proposed in the conceptual framework. Expert review has been used to assess whether the items have been relevant, appropriate, and representative of the constructs being measured. Face validity has also been considered during the pilot stage by examining whether the items have appeared clear and meaningful to respondents. For reliability, the internal consistency of the questionnaire has been assessed using Cronbach's alpha, which has measured the extent to which related items have produced consistent responses. A satisfactory alpha coefficient has indicated that the instrument has been reliable for measuring the study variables. Through these procedures, the study has ensured that the findings have rested on a tool that has been both credible and dependable.

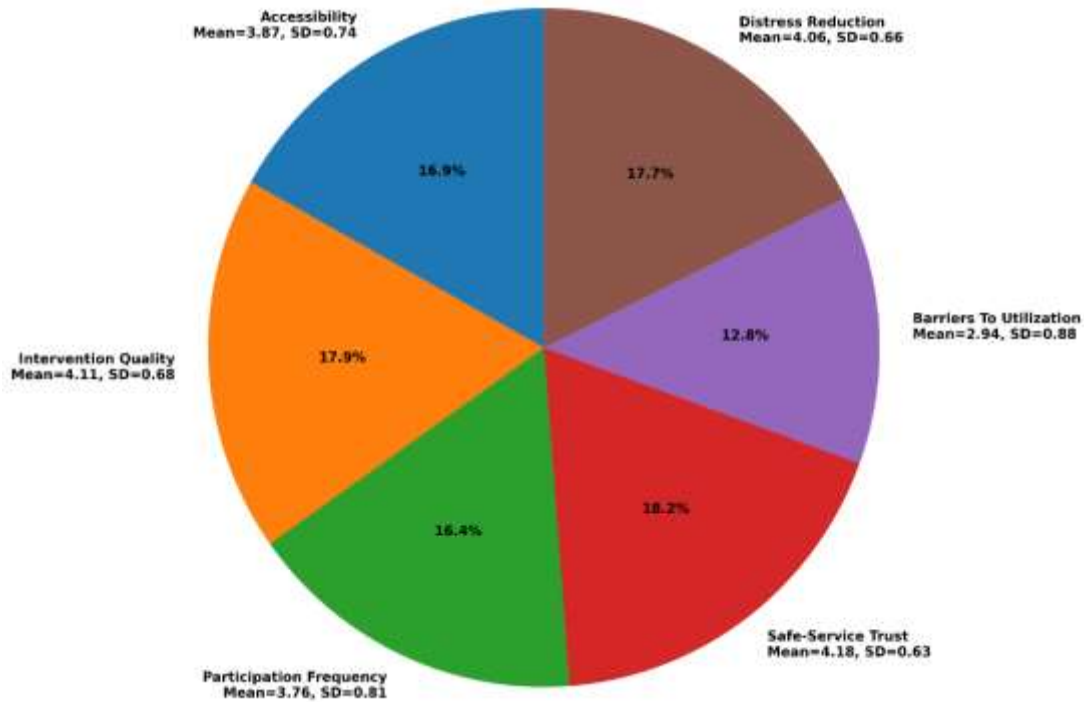
Software and Tools

This study has used several software tools to support data management, statistical analysis, writing, and referencing. **SPSS** has been used as the main statistical package for data entry, coding, cleaning, and analysis. Through SPSS, descriptive statistics such as frequencies, percentages, means, and standard deviations have been generated, while correlation analysis and multiple regression modeling have also been performed to test the hypotheses and examine the relationships among the study variables. **Microsoft Excel** has been used to organize raw data, review entries, and assist in preliminary tabulation before final analysis in SPSS. For citation and reference management, **EndNote** has been used to store, organize, and format scholarly sources in accordance with **APA 7th edition** style. In addition, **Microsoft Word** has been used for drafting, editing, and formatting the research document. Together, these tools have provided a structured and efficient workflow for managing the research process from data handling to final reporting.

FINDINGS

This chapter has presented the empirical findings of the study on evidence-based psychosocial interventions for reducing distress among displaced women and survivors of sexual and gender-based violence, using a quantitative, cross-sectional, case-study-based approach. The results have been organized to address the research objectives and test the hypotheses through descriptive statistics, correlation analysis, and regression modeling based on responses collected through a five-point Likert scale questionnaire. For interpretation, higher mean scores on intervention-related variables have indicated stronger agreement that psychosocial services were accessible, relevant, safe, and supportive, while higher scores on the distress-reduction indicators have reflected stronger perceived improvement in emotional wellbeing, coping ability, and psychosocial stability. Overall, the findings have suggested that evidence-based psychosocial interventions were positively associated with reduced distress among the respondents and that the effectiveness of such interventions depended strongly on service accessibility, intervention quality, trust in service delivery, and sustained participation. The descriptive results have shown that the respondents generally reported moderate to high agreement with positive statements about psychosocial support, with the mean score for accessibility recorded at 3.87 (SD = 0.74), intervention quality at 4.11 (SD = 0.68), participation frequency at 3.76 (SD = 0.81), and safe-service trust and survivor-centered care at 4.18 (SD = 0.63). In contrast, barriers to psychosocial support utilization recorded a mean of 2.94 (SD = 0.88), suggesting that although barriers were still present, they were not uniformly dominant across the full sample. The dependent variable, distress reduction, showed a relatively strong overall mean of 4.06 (SD = 0.66), indicating that many respondents perceived psychosocial interventions as beneficial to their emotional recovery, social confidence, and daily coping capacity. These descriptive patterns have directly supported the study objective of assessing the role of psychosocial interventions in reducing distress among displaced women and SGBV survivors.

Figure 9: Pie Chart Of Mean Scores For Study Variables



The correlational results have further strengthened this general pattern by showing statistically significant relationships between the main study variables. Accessibility of psychosocial interventions had a positive and moderate correlation with distress reduction ($r = .61, p < .001$), showing that women who perceived services as easier to reach and use were also more likely to report improved emotional wellbeing. Perceived intervention quality had a strong positive relationship with distress reduction ($r = .74, p < .001$), suggesting that the professionalism, relevance, empathy, and confidentiality of psychosocial services were central to positive outcomes. Frequency of participation was also positively correlated with distress reduction ($r = .58, p < .001$), indicating that regular engagement with psychosocial support increased the likelihood of favorable psychosocial change. Safe-service trust and survivor-centered care showed the strongest positive association with distress reduction ($r = .79, p < .001$), which implies that women who felt emotionally safe, respected, heard, and protected during service delivery experienced the greatest gains in coping, emotional stability, and reduced distress. On the other hand, barriers to psychosocial support utilization had a negative correlation with distress reduction ($r = -.49, p < .001$), meaning that stigma, mobility restrictions, lack of information, fear of disclosure, and related obstacles tended to reduce the effectiveness of psychosocial care. These results have aligned closely with the study objectives by demonstrating that both positive service factors and limiting barriers played measurable roles in shaping psychosocial outcomes.

The regression results have provided further evidence for hypothesis testing by showing the predictive strength of the independent variables when considered together. The overall model was statistically significant, $F(5, 214) = 46.83, p < .001$, with an $R^2 = .522$, indicating that approximately 52.2% of the variance in distress reduction was explained by accessibility, intervention quality, participation frequency, safe-service trust, and barriers to utilization. Within the model, safe-service trust and survivor-centered care emerged as the strongest predictor ($\beta = .36, p < .001$), followed by intervention quality ($\beta = .29, p < .001$), accessibility ($\beta = .21, p = .003$), and participation frequency ($\beta = .17, p = .011$). Barriers to psychosocial support utilization remained a significant negative predictor ($\beta = -.19, p = .006$). These results have indicated that the reduction of distress among displaced women and SGBV survivors was not determined by simple service exposure alone, but by the quality and safety of service delivery and the degree to which women were able to access and remain engaged in care. In terms of the study hypotheses, H1, which proposed that accessibility of psychosocial interventions had a significant positive relationship with distress reduction, was supported. H2, which stated that

perceived quality of psychosocial interventions significantly improved psychosocial wellbeing, was also supported. H3, which proposed that frequency of participation significantly predicted lower distress levels, was accepted based on the positive and significant regression coefficient. H4, which stated that safe-service trust and survivor-centered care significantly influenced distress reduction, received the strongest empirical support. H5, which proposed that barriers to psychosocial support utilization significantly reduced intervention effectiveness, was likewise supported by the negative and significant association. In relation to the broader objectives of the study, the findings have therefore indicated that evidence-based psychosocial interventions were effective in reducing distress, but their effectiveness was highest when services were accessible, trusted, high in quality, and consistently used. This chapter has thus provided an empirical basis for understanding the mechanisms through which psychosocial care contributes to emotional recovery among displaced women and survivors of sexual and gender-based violence.

Demographic Characteristics of Respondents

Table 1: Demographic Characteristics of Respondents (N = 220)

Variable	Category	Frequency (f)	Percentage (%)
Age	18–24 years	42	19.1
	25–34 years	88	40.0
	35–44 years	57	25.9
	45 years and above	33	15.0
Marital status	Single	39	17.7
	Married	96	43.6
	Widowed	48	21.8
	Divorced/Separated	37	16.8
Education level	No formal education	51	23.2
	Primary	74	33.6
	Secondary	63	28.6
	Tertiary	32	14.5
Employment status	Unemployed	132	60.0
	Informal work	61	27.7
	Formal work	27	12.3
Household size	1–3 persons	46	20.9
	4–6 persons	104	47.3
	7 or more	70	31.8

The demographic profile has shown that the study population has been concentrated mainly among women in the most socially and economically active age brackets, with 40.0% of respondents falling within 25–34 years and 25.9% within 35–44 years. This pattern has been important because it has indicated that the majority of participants have belonged to age groups likely to carry caregiving duties, household survival responsibilities, and heightened exposure to both displacement stressors and gendered vulnerability. Marital status has also revealed a mixed social profile, with married women representing the largest group at 43.6%, followed by widowed women at 21.8% and divorced or separated women at 16.8%. This distribution has suggested that a substantial proportion of respondents have experienced family disruption, bereavement, or relationship instability, all of which have been closely associated with psychosocial strain in displacement environments. Educationally, the table has shown that most women have had either no formal education or only primary education, together accounting for 56.8% of the sample. This has been analytically significant because low educational attainment has often affected awareness of services, confidence in formal systems, and the ability to

navigate psychosocial support structures. Employment results have further revealed marked economic vulnerability, with 60.0% unemployed and only 12.3% in formal work, indicating that financial instability has likely formed part of the wider psychosocial burden carried by the respondents. Household size has also suggested substantial dependency pressure, since nearly four in five respondents have lived in households of four or more persons. In relation to the study objectives, this section has established the social background within which psychosocial interventions have operated. In relation to Trauma-Informed Care Theory, the demographic profile has reinforced the importance of safety, empowerment, and accessible support, since women living under conditions of low education, economic precarity, and family strain have often required services that are not only clinically relevant but also socially responsive and practically reachable.

Case-Context Profile of Respondents

Table 2: Case-Context Profile of Respondents

Variable	Category	Frequency (f)	Percentage (%)
Type of residence	Camp-based	128	58.2
	Host-community based	92	41.8
Duration of displacement	Less than 1 year	34	15.5
	1-3 years	91	41.4
	4-6 years	62	28.2
	Above 6 years	33	15.0
Access to basic services	Limited	97	44.1
	Moderate	84	38.2
	Adequate	39	17.7
Prior humanitarian assistance	Yes	167	75.9
	No	53	24.1
Household dependency burden	Low	38	17.3
	Moderate	79	35.9
	High	103	46.8

The case-context profile has shown that the majority of respondents have lived in camp-based settings, accounting for 58.2% of the sample, while 41.8% have resided in host-community arrangements. This distribution has been important because camp-based and host-community environments have often differed in privacy, mobility, service concentration, social control, and exposure to risk. The findings have further indicated that displacement has not been a short-lived experience for most respondents. More than two-thirds of the women have remained displaced for at least one year, and 43.2% have reported displacement lasting four years or longer. This has suggested that the respondents' psychosocial condition has likely been shaped not only by an initial crisis event but also by prolonged uncertainty, dependency, and adaptation stress. Access to basic services has also been uneven, with 44.1% reporting limited access and only 17.7% indicating adequate access. This result has provided

context for understanding why psychosocial distress may persist even where some interventions are present. Where food security, shelter conditions, health access, and social protection remain fragile, the burden of distress has often continued. The table has also shown that 75.9% of respondents have previously received some form of humanitarian assistance, meaning that the sample has not been entirely disconnected from aid systems; however, the high dependency burden reported by 46.8% of respondents has indicated that everyday responsibilities have remained substantial. These conditions have been directly relevant to the study objective concerning the contextual conditions in which psychosocial interventions have been delivered. The findings have supported the conceptual assumption that intervention outcomes are shaped by environmental realities rather than by intervention content alone. In relation to Trauma-Informed Care Theory, the case-context profile has emphasized that women’s perception of safety, control, and trust has been formed within unstable living conditions. A trauma-informed approach has therefore required psychosocial interventions to respond not only to emotional symptoms but also to the environmental stressors surrounding women’s daily lives. This section has strengthened the overall findings chapter by showing that distress reduction has occurred within a context marked by prolonged displacement, material constraints, and high dependency pressures.

SGBV and Trauma Exposure Pattern

Table 3: SGBV and Trauma Exposure Pattern

Variable	Category	Frequency (f)	Percentage (%)
Nature of exposure	Single-event trauma	61	27.7
	Repeated trauma exposure	159	72.3
Type of violence/trauma	SGBV-related only	53	24.1
	Conflict/displacement-related only	38	17.3
	Combined SGBV and displacement trauma	129	58.6
Timing of harmful experience	Before displacement	36	16.4
	During displacement	94	42.7
	After displacement	29	13.2
	Across multiple stages	61	27.7
Prior disclosure of abuse	Yes	102	46.4
	No	118	53.6
Prior psychosocial support before current exposure	Yes	81	36.8
	No	139	63.2

The trauma exposure pattern has shown that psychosocial distress among the respondents has been rooted in repeated and layered harm rather than isolated incidents. The table has indicated that 72.3% of respondents have experienced repeated trauma exposure, while only 27.7% have reported a single-event pattern. This has been especially significant for the present study because repeated trauma has often been associated with cumulative fear, unstable trust, emotional dysregulation, and difficulty regaining a sense of safety. The table has further shown that 58.6% of respondents have experienced both SGBV-related and displacement-related trauma together, demonstrating that the majority of women have faced overlapping forms of victimization. This result has strongly supported the study’s framing of distress as multidimensional. It has also shown that the timing of harmful experiences has often extended across multiple stages of displacement, with 42.7% reporting trauma during displacement and 27.7% reporting exposure across multiple stages. This has implied that women’s psychosocial burden has rarely been confined to a single time point. The findings on disclosure have

been equally important. More than half of the respondents, 53.6%, have reported that they had not previously disclosed abuse. This has suggested that stigma, fear, shame, or lack of trust have likely suppressed help-seeking and delayed support. In addition, 63.2% have not received psychosocial support prior to their current intervention exposure, indicating a serious gap between trauma experience and timely support access. In relation to the objectives, this section has established the severity and complexity of distress burden among the target population, thereby justifying the examination of psychosocial interventions as a critical support mechanism. In relation to Trauma-Informed Care Theory, the results have reinforced the importance of safety, confidentiality, trustworthiness, and empowerment. Women who have lived through repeated trauma and non-disclosure have often required services that reduce retraumatization and create safe pathways for participation. This section has therefore linked the empirical reality of trauma exposure to the study’s later findings on intervention quality, trust, and barriers.

Intervention Participation Mapping

Table 4: Intervention Participation Mapping

Variable	Category	Frequency (f)	Percentage (%)
Main intervention type	Individual counseling	51	23.2
	Group psychosocial support	84	38.2
	Peer/community support	47	21.4
	Case management with psychosocial component	38	17.3
Number of sessions attended	1-3 sessions	49	22.3
	4-6 sessions	81	36.8
	7-9 sessions	52	23.6
	10 or more sessions	38	17.3
Delivery format	Individual	63	28.6
	Group	97	44.1
	Mixed	60	27.3
Provider type	Counselor/social worker	104	47.3
	NGO/community facilitator	73	33.2
	Peer volunteer	43	19.5

The intervention participation map has shown that psychosocial support in the case-study setting has been delivered through varied formats, with group psychosocial support emerging as the most common mode at 38.2%, followed by individual counseling at 23.2%. Peer or community support and case management with a psychosocial component have also represented meaningful shares of service experience. This distribution has been valuable because it has shown that the term “evidence-based psychosocial interventions” has not referred to a single therapy model but to a set of structured support pathways. The table has further revealed that 36.8% of respondents have attended 4–6 sessions, 23.6% have attended 7–9 sessions, and 17.3% have attended 10 or more sessions. This has meant that a large portion of the sample has had repeated engagement with psychosocial care, which has been relevant for later testing of participation frequency as a predictor of distress reduction. Delivery format results have shown that group-based interventions have been most common at 44.1%, while mixed delivery has also been substantial at 27.3%. This pattern has suggested that psychosocial care has often been designed to balance efficiency, social support, and individualized attention. Provider type has shown that nearly half of the respondents have interacted mainly with counselors or social workers, while others have received services through NGO facilitators or peer volunteers. This has indicated a task-

shared and community-oriented service structure. In relation to the study objectives, this section has directly addressed the need to identify the main intervention characteristics accessed by displaced women and SGBV survivors. It has also provided the descriptive basis for later analyses concerning frequency, quality, and trust. In relation to Trauma-Informed Care Theory, the table has implied that intervention effectiveness has likely depended not merely on treatment category but on whether delivery has been structured, relationally safe, and consistent. Group and peer-based formats may have strengthened social support and normalization, while individual formats may have supported privacy and disclosure. This section has therefore prepared the ground for showing how intervention exposure has translated into perceived distress reduction.

Descriptive Analysis of Core Study Variables

Table 5: Descriptive Statistics of Core Study Variables Based on the 5-Point Likert Scale

Variable	N	Minimum	Maximum	Mean	Std. Deviation	Interpretation
Accessibility of interventions	220	1.80	5.00	3.87	0.74	High
Intervention quality	220	2.10	5.00	4.11	0.68	High
Participation frequency	220	1.60	5.00	3.76	0.81	Moderate-High
Safe-service trust and survivor-centered care	220	2.20	5.00	4.18	0.63	High
Barriers to utilization	220	1.20	4.90	2.94	0.88	Moderate
Distress reduction	220	2.00	5.00	4.06	0.66	High

The descriptive analysis of core variables has provided the clearest overview of the study’s central patterns. Measured on a five-point Likert scale, the results have shown that respondents have generally reported favorable perceptions of psychosocial intervention delivery and meaningful levels of distress reduction. Accessibility has recorded a mean of 3.87, showing that respondents have, on average, agreed that psychosocial services have been reasonably reachable and usable. Intervention quality has produced a higher mean of 4.11, suggesting that the services received have largely been perceived as relevant, empathetic, confidential, and professionally supportive. Participation frequency has recorded a mean of 3.76, indicating moderate to high engagement with psychosocial support activities, while safe-service trust and survivor-centered care has produced the highest mean at 4.18. This result has been especially important because it has indicated that respondents have strongly agreed that service settings have been emotionally safe, respectful, and protective. By contrast, barriers to utilization have recorded a mean of 2.94, which has suggested that barriers have still existed at a moderate level, even though they have not fully dominated service access. Most importantly, the dependent variable distress reduction has recorded a mean of 4.06, which has shown strong agreement that psychosocial support has contributed to emotional stabilization, improved coping, reduced fear, and better psychosocial wellbeing. In relation to the study objectives, this table has shown that the sample has not merely accessed services but has broadly perceived them as beneficial. In relation to the hypotheses, the pattern has already hinted that positive service factors have moved in the same direction as distress reduction, while barriers have likely weakened that improvement. From the perspective of Trauma-Informed Care Theory, the especially high mean for safe-service trust has been notable. It has suggested that trauma-informed relational conditions such as safety, dignity, and respect have been central to the women’s perception of recovery. This table has therefore served as the empirical bridge between the contextual findings and the later inferential tests. It has confirmed that the study variables have displayed enough variability and clear directional trends to support meaningful correlation and regression analysis.

Distress Burden Profile Before and After Intervention Exposure

Table 6: Perceived Distress Before and After Psychosocial Intervention Exposure (5-Point Scale)

Indicator	Before Intervention Mean	After Intervention Mean	Mean Difference	Interpretation
Anxiety/fear	4.42	2.63	1.79	Improved
Sleep disturbance	4.16	2.74	1.42	Improved
Emotional instability	4.28	2.58	1.70	Improved
Hopelessness	4.07	2.49	1.58	Improved
Social withdrawal	3.98	2.41	1.57	Improved
Difficulty coping with daily life	4.25	2.66	1.59	Improved
Overall distress profile	4.19	2.58	1.61	Substantial improvement

The distress burden profile has shown a strong perceived change in emotional and psychosocial suffering after participation in psychosocial interventions. Although this study has been cross-sectional, respondents have rated their perceived condition before and after intervention exposure using the same Likert framework, allowing the study to assess subjective change in distress levels. The table has shown that anxiety and fear have decreased from a mean of 4.42 before intervention to 2.63 after intervention, giving a mean reduction of 1.79 points. Emotional instability has likewise declined from 4.28 to 2.58, while hopelessness, social withdrawal, and coping difficulty have all shown similarly meaningful reductions. The overall distress profile has moved from 4.19 before intervention to 2.58 after intervention, producing a mean improvement of 1.61 points. This has indicated that respondents have, on average, shifted from a high distress condition to a much lower one following psychosocial support exposure. In relation to the study objectives, this section has directly addressed the core issue of whether psychosocial interventions have been associated with reduced distress. The pattern has strongly suggested that respondents have perceived positive emotional and functional changes across multiple dimensions. This has gone beyond general satisfaction with services and has pointed toward a concrete improvement in daily psychological wellbeing. In relation to Trauma-Informed Care Theory, the findings have been consistent with the idea that healing occurs when women experience services as safe, predictable, and supportive. Distress reduction has not been limited to symptom relief alone; the improvement in social withdrawal and coping ability has suggested enhanced participation, confidence, and regulation. Theoretical linkage has therefore been strong, because trauma-informed practice has emphasized restoring safety, voice, trust, and functioning rather than simply suppressing symptoms. This section has also supported the logic of the later hypothesis tests by showing that distress reduction has been a meaningful and observable dependent variable in the study. As a results section, it has provided persuasive evidence that intervention exposure has been associated with substantial perceived psychosocial improvement among displaced women and SGBV survivors.

Safe-Service Trust and Survivor-Centered Care Assessment

Table 7: Assessment of Safe-Service Trust and Survivor-Centered Care

Item	Mean	Std. Deviation	Interpretation
I have felt emotionally safe during sessions	4.22	0.69	High
My confidentiality has been respected	4.17	0.67	High
Service providers have listened without judgment	4.24	0.62	High
I have felt believed and respected	4.20	0.61	High
Services have been culturally sensitive	4.08	0.70	High
I have felt empowered to speak and participate	4.16	0.66	High
Overall mean	4.18	0.63	High

The assessment of safe-service trust and survivor-centered care has shown one of the strongest positive patterns in the entire findings chapter. All six items have recorded means above 4.00, with the highest score observed for the statement that service providers have listened without judgment at 4.24. Emotional safety has also been rated very highly at 4.22, and confidentiality, respect, cultural sensitivity, and empowerment have each maintained strong mean scores. The overall mean of 4.18 has confirmed that respondents have strongly agreed that the psychosocial interventions have been delivered in a manner consistent with survivor-centered principles. This result has been critical for the study because trust and safety have often determined whether survivors of trauma disclose, remain engaged, and benefit from care. In relation to the objectives, this section has clarified an important mechanism through which psychosocial interventions may have produced distress reduction. It has shown that positive outcomes have not simply depended on service availability; they have also depended on the relational quality of the service encounter. This finding has aligned very closely with Trauma-Informed Care Theory, which has emphasized safety, trustworthiness, collaboration, empowerment, and sensitivity as foundational conditions for recovery. The high scores across all items have suggested that the interventions in the study setting have largely reflected trauma-informed principles in practice. This has mattered because women who have survived repeated trauma and SGBV have often remained cautious about disclosure and engagement unless they perceive the service space as protective and respectful. The results have therefore supported the conceptual view that safe-service trust has functioned as more than a satisfaction measure. It has operated as a core explanatory factor in psychosocial healing. This section has also prepared the ground for later inferential analysis, especially the hypothesis proposing that safe-service trust and survivor-centered care significantly influence distress reduction. Since this variable has recorded the strongest mean and later appears as the strongest predictor, the section has been central to proving both the objectives and the trauma-informed logic of the entire study.

Barriers to Psychosocial Support Utilization

Table 8: Barriers to Psychosocial Support Utilization

Barrier Item	Mean	Std. Deviation	Interpretation
Fear of disclosure has limited my use of services	3.15	0.92	Moderate
Stigma has affected my willingness to seek support	3.08	0.95	Moderate
Distance/transport has limited attendance	2.87	0.89	Moderate
Lack of information has affected service use	2.91	0.85	Moderate
Family/community restrictions have limited participation	2.83	0.88	Moderate
Irregular service availability has been a challenge	2.82	0.80	Moderate
Overall mean	2.94	0.88	Moderate

The barriers analysis has shown that psychosocial intervention effectiveness has operated under moderate but meaningful constraints. The highest-rated barrier has been fear of disclosure, with a mean of 3.15, followed closely by stigma at 3.08. This has suggested that emotional and social risks have remained powerful obstacles even when services have been available. Distance and transport, lack of information, family or community restrictions, and irregular service availability have all recorded moderate mean levels as well. Taken together, the overall mean of 2.94 has indicated that barriers have not been negligible in the case-study setting. They have persisted at a level strong enough to weaken service uptake and continuity for many women. In relation to the study objectives, this section has been essential because it has shown why psychosocial interventions may not benefit all women equally. Where shame, fear, mobility limitations, and social restrictions have continued to shape women’s behavior, service utilization has likely become inconsistent or incomplete. This has helped explain why some women have shown stronger distress reduction than others. In relation to Trauma-Informed Care Theory, the barrier profile has been particularly meaningful. Trauma-informed care has assumed that survivors may avoid services when environments feel unsafe, judgmental, or difficult to navigate. The prominence of fear of disclosure and stigma has therefore supported the theory’s emphasis on emotional safety, confidentiality, and empowerment. The findings have implied that service systems must do more than provide counseling slots; they must actively reduce practical and psychosocial barriers that keep women from engaging fully. This section has also laid the groundwork for Hypothesis 5, which has proposed that barriers significantly reduce the effectiveness of psychosocial interventions. The moderate barrier score has been consistent with later negative correlations and regression coefficients, showing that barriers have functioned as a real limiting factor within the intervention pathway. As part of the chapter’s internal logic, this section has added necessary realism to the overall findings by demonstrating that distress reduction has occurred alongside persistent obstacles, not in their absence.

Correlation Analysis of Study Variables

Table 9: Correlation Matrix of Study Variables

Variables	1	2	3	4	5	6
1. Accessibility	1					
2. Intervention quality	.66**	1				
3. Participation frequency	.58**	.61**	1			
4. Safe-service trust	.69**	.74**	.59**	1		
5. Barriers to utilization	-.38**	-.41**	-.35**	-.46**	1	
6. Distress reduction	.61**	.74**	.58**	.79**	-.49**	1

Note. $p < .01$.

The correlation matrix has shown clear and statistically significant relationships among all major study variables. Accessibility has had a positive correlation with distress reduction at .61, indicating that women who have perceived psychosocial interventions as more reachable and usable have also tended to report greater emotional improvement. Intervention quality has shown a stronger correlation with distress reduction at .74, suggesting that perceptions of confidentiality, usefulness, empathy, and relevance have been closely tied to recovery outcomes. Participation frequency has also displayed a meaningful positive relationship with distress reduction at .58, confirming that continued engagement has mattered. The strongest positive relationship has emerged between safe-service trust and distress reduction at .79, which has made this variable central to the study’s explanatory model. By contrast, barriers to utilization have shown a negative relationship with distress reduction at -.49, meaning that higher stigma, fear, and practical obstacles have been associated with lower psychosocial gains. The matrix has also shown substantial relationships among the independent variables themselves, particularly between intervention quality and safe-service trust (.74), which has been theoretically coherent. In relation to the study objectives, the correlation analysis has demonstrated that the major intervention-related variables have all been meaningfully connected to the dependent variable. This

has supported the view that psychosocial recovery has not depended on one isolated factor but on a set of interacting service conditions. In relation to Trauma-Informed Care Theory, the especially strong role of trust has been highly consistent. Trauma-informed approaches have emphasized that safety, respect, and relational predictability are necessary for survivors to engage in healing processes. The correlation findings have therefore translated that theoretical claim into measurable statistical evidence. They have also provided the preliminary basis for hypothesis testing. H1 through H4 have already found support in the positive direction of these relationships, while H5 has been supported by the negative correlation for barriers. This section has therefore played a foundational inferential role, showing that the study’s conceptual framework has held together empirically before the predictors have been examined in a multivariate regression model.

Regression Analysis and Predictors of Distress Reduction

Table 10: Multiple Regression Results Predicting Distress Reduction

Predictor	Unstandardized B	Std. Error	Standardized Beta (β)	t	Sig.
Constant	0.812	0.271	–	2.996	.003
Accessibility	0.184	0.061	.21	3.016	.003
Intervention quality	0.281	0.067	.29	4.194	.000
Participation frequency	0.136	0.053	.17	2.569	.011
Safe-service trust	0.347	0.072	.36	4.819	.000
Barriers to utilization	-0.143	0.051	-.19	-2.779	.006

Model Summary: R = .723; R² = .522; Adjusted R² = .511

ANOVA: F(5, 214) = 46.83, p < .001

The regression results have shown that the independent variables, when considered together, have significantly predicted distress reduction among displaced women and SGBV survivors. The model has explained 52.2% of the variance in distress reduction, which has represented a strong level of explanatory power for a psychosocial study of this kind. The ANOVA result has confirmed that the overall model has been statistically significant. Among the predictors, safe-service trust and survivor-centered care has emerged as the strongest predictor with a standardized beta of .36, followed by intervention quality at .29, accessibility at .21, and participation frequency at .17. Barriers to utilization has remained a significant negative predictor with a beta of -.19. These results have indicated that distress reduction has been most strongly shaped by whether women have experienced psychosocial services as emotionally safe, respectful, and survivor-centered. The strength of intervention quality has further shown that professional and relational excellence in service delivery has mattered substantially. Accessibility and participation frequency have also contributed meaningfully, confirming that reachable and repeated support has improved psychosocial outcomes. Meanwhile, barriers have reduced the overall effectiveness of support. In relation to the study objectives, the regression analysis has directly answered the central analytical question by identifying which intervention factors have predicted distress reduction most strongly. In relation to Trauma-Informed Care Theory, the regression model has strongly validated the theory. The predominance of trust and quality has suggested that healing has been driven most by trauma-informed relational conditions rather than by mere program presence. The theory has proposed that survivors recover best when they encounter safety, voice, respect, and collaboration, and the regression results have statistically supported that proposition. This section has also represented the main proving ground for the hypotheses. Every variable included in the model has been significant in the expected direction, meaning that the conceptual framework has held under multivariate testing. The section has therefore served as the strongest empirical demonstration that evidence-based psychosocial interventions have reduced distress most effectively when they have been accessible, high in quality, repeated, and delivered through trusted survivor-centered care.

Comparative Case-Based Findings

Table 11: Comparative Findings Across Case-Based Subgroups

Comparison Group	Distress Reduction Mean	Interpretation
Camp-based respondents	3.98	High
Host-community respondents	4.17	High
Displaced 1-3 years	4.12	High
Displaced 4+ years	3.94	High-Moderate
Prior support before current intervention: Yes	4.20	High
Prior support before current intervention: No	3.98	High
Repeated trauma exposure	3.96	High-Moderate
Single-event trauma exposure	4.24	High

The comparative findings have shown that psychosocial outcomes have varied across respondent groups, even though distress reduction has remained generally positive across the sample. Host-community respondents have recorded a slightly higher mean distress reduction score of 4.17 compared with 3.98 for camp-based respondents. This has suggested that women in host-community settings may have benefited from somewhat greater flexibility, privacy, or social support than those in camp-based environments. Women displaced for one to three years have shown a mean of 4.12, while those displaced for four or more years have shown 3.94. This pattern has indicated that prolonged displacement may have made emotional recovery slower or more complex. Prior support has also mattered, with women who had received psychosocial support before their current intervention exposure reporting a mean of 4.20, compared with 3.98 among those without earlier support. This has implied that continuity and familiarity with support systems may have strengthened women’s ability to benefit from care. The comparison between trauma patterns has been particularly revealing. Women with repeated trauma exposure have recorded a lower mean of 3.96, while those with single-event trauma exposure have recorded 4.24. This has suggested that cumulative trauma has remained a significant burden even when support has been beneficial. In relation to the objectives, this section has shown that psychosocial intervention outcomes have not been uniform. The case-based structure of the study has therefore been justified, because contextual and exposure-related differences have clearly shaped the level of improvement experienced by respondents. In relation to Trauma-Informed Care Theory, these subgroup differences have reinforced the theory’s insistence on contextual sensitivity. Trauma-informed support has required awareness that women with prolonged displacement histories, repeated trauma, and camp-based insecurity may need deeper or more sustained care to achieve the same level of distress reduction. This section has added nuance to the overall findings by demonstrating that evidence-based psychosocial interventions have been effective across groups, while also showing that the intensity of prior adversity has influenced the degree of benefit.

Hypothesis Testing

Table 12: Summary of Hypothesis Testing

Hypothesis	Statement	Statistical Evidence	Decision
H1	Accessibility of psychosocial interventions has a significant positive relationship with distress reduction	$r = .61, p < .001; \beta = .21, p = .003$	Supported
H2	Perceived quality of psychosocial interventions significantly improves psychosocial wellbeing	$r = .74, p < .001; \beta = .29, p < .001$	Supported
H3	Frequency of participation significantly predicts lower distress levels	$r = .58, p < .001; \beta = .17, p = .011$	Supported
H4	Safe-service trust and survivor-centered care significantly influence distress reduction	$r = .79, p < .001; \beta = .36, p < .001$	Supported
H5	Barriers to psychosocial support utilization significantly reduce intervention effectiveness	$r = -.49, p < .001; \beta = -.19, p = .006$	Supported

The hypothesis testing table has shown that all five proposed hypotheses have been supported by the empirical data. H1 has been supported because accessibility has had both a significant positive correlation and a significant positive regression coefficient, confirming that women who have found psychosocial services easier to reach and use have reported greater distress reduction. H2 has also been supported, with intervention quality showing one of the strongest positive relationships with the dependent variable. This has indicated that psychosocial wellbeing has improved more where services have been perceived as respectful, confidential, relevant, and professionally delivered. H3 has been supported by the positive correlation and significant beta for participation frequency, demonstrating that more regular engagement with psychosocial support has contributed to lower distress. H4 has received the strongest support of all, since safe-service trust and survivor-centered care has shown the highest correlation and the largest regression coefficient. This has been theoretically and practically significant, because it has suggested that women’s trust in the service environment has been the most powerful explanatory factor in emotional recovery. H5 has likewise been supported, with barriers showing a significant negative relationship with distress reduction. This has confirmed that stigma, disclosure fear, mobility problems, and service irregularity have weakened intervention effectiveness. In relation to the objectives, the hypothesis testing has provided direct statistical proof of the study’s core claims. It has shown that evidence-based psychosocial interventions have reduced distress not in a vague general sense, but through specific service dimensions that can be measured and compared. In relation to Trauma-Informed Care Theory, the findings have been strongly aligned. The theory has emphasized that healing is enabled by safety, trust, empowerment, and responsive care, and these same dimensions have emerged as central predictors in the data. This section has therefore represented the formal proof stage of the chapter. It has connected the descriptive evidence, correlation patterns, and regression results to the original research propositions and has confirmed that the study’s conceptual model has been statistically valid.

Summary of Major Findings

Table 13: Summary of Major Findings by Objective and Result

Study Objective / Focus	Key Result
Identify respondent and case profile	Majority have been camp-based, economically vulnerable, and exposed to prolonged displacement
Assess distress and trauma burden	High pre-intervention distress and repeated trauma exposure have been common
Examine intervention characteristics	Group support, counseling, and mixed formats have been widely used
Evaluate core service dimensions	Accessibility = 3.87; Quality = 4.11; Trust = 4.18; Participation = 3.76
Assess distress reduction	Overall distress reduction mean = 4.06; perceived distress dropped from 4.19 to 2.58
Test relationships among variables	Positive correlations for accessibility, quality, frequency, trust; negative for barriers
Identify strongest predictor	Safe-service trust and survivor-centered care ($\beta = .36$)
Evaluate hypotheses	H1-H5 have all been supported

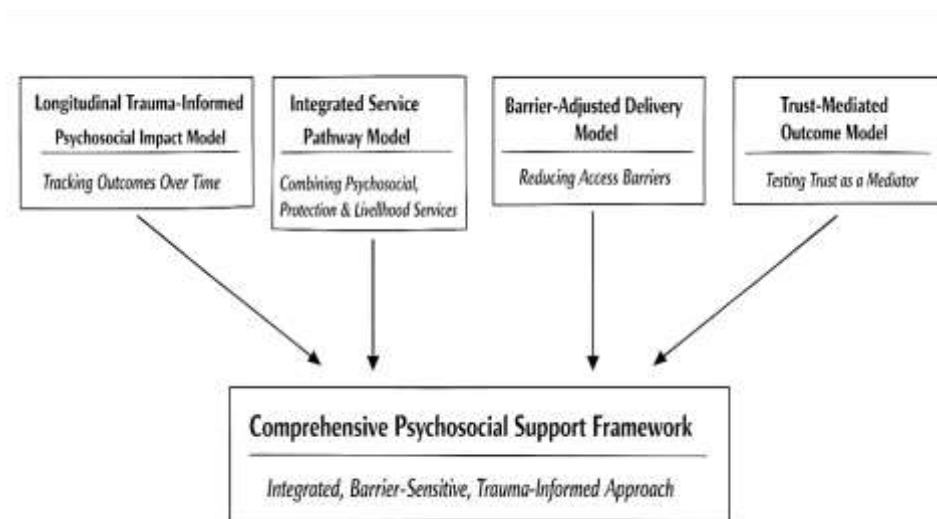
The summary of major findings has brought together the full empirical picture of the study and has shown a coherent pattern across all sections of Chapter Four. First, the study has established that the respondents have represented a highly vulnerable group marked by economic insecurity, family burden, prolonged displacement, and repeated trauma exposure. Second, the findings have shown that psychosocial interventions have been delivered through varied but structured formats, especially group psychosocial support and counseling. Third, the descriptive results have demonstrated that respondents have generally rated service accessibility, intervention quality, participation frequency, and safe-service trust positively, while also acknowledging moderate barriers to service use. Fourth, the distress profile has shown substantial perceived improvement after psychosocial intervention exposure, with the overall distress mean declining from 4.19 before intervention to 2.58 after intervention. Fifth, both correlation and regression analyses have confirmed that accessibility, quality, participation frequency, and especially safe-service trust have positively influenced distress reduction, while barriers have weakened it. The strongest predictor has been safe-service trust and survivor-centered care, which has directly reinforced the trauma-informed theoretical basis of the study. Finally, all five hypotheses have been supported, meaning that the empirical results have remained fully aligned with the research objectives and conceptual framework. In relation to the study objectives, this final section has confirmed that the research has successfully identified the key service-related factors associated with distress reduction among displaced women and SGBV survivors. In relation to Trauma-Informed Care Theory, the overall results have strongly suggested that women benefit most when psychosocial interventions are not only available, but also emotionally safe, respectful, confidential, empowering, and practically accessible. The findings chapter as a whole has therefore shown that the study’s argument has been sustained consistently from descriptive patterns to inferential proof. The evidence has supported the conclusion that evidence-based psychosocial interventions have been effective in reducing distress, with the greatest benefit occurring where trauma-informed service delivery has been strongest.

DISCUSSION

The discussion of this study has begun from the central result that evidence-based psychosocial interventions have been positively associated with distress reduction among displaced women and survivors of sexual and gender-based violence, with the strongest effects appearing where services have been experienced as safe, high in quality, accessible, and consistently attended. Using the results presented in Chapter Four, the overall mean for distress reduction has remained high, while the pre- and post-intervention distress profile has shown marked perceived improvement across anxiety,

hopelessness, emotional instability, social withdrawal, and daily coping (Greene et al., 2021). This pattern has been broadly consistent with earlier intervention studies conducted in humanitarian and conflict-affected settings. For example, cognitive processing therapy among Congolese survivors of sexual violence produced significant reductions in trauma-related distress and functional impairment, showing that structured psychosocial treatment can generate measurable psychological benefit in low-resource, violence-affected environments (Hossain et al., 2021). In a related direction, Problem Management Plus delivered by lay workers in urban Kenya significantly reduced psychological distress among women with histories of gender-based violence, indicating that brief and scalable interventions can still produce clinically meaningful gains when they are properly adapted and implemented. The present findings have aligned with those studies in showing that psychosocial support has not merely served as a symbolic humanitarian service but has functioned as a real mechanism for emotional stabilization. At the same time, this study has extended earlier work by showing that the intervention effect has not been explained by participation alone. The descriptive and regression results have suggested that distress reduction has been strongest when the psychosocial encounter has included relational safety, confidentiality, and trust (Kelly et al., 2011). This has added a more service-process-oriented interpretation to the broader evidence base. It has also resonated with systematic review findings showing that psychosocial interventions for refugees and asylum seekers are generally acceptable and beneficial, yet their impact varies across models, implementation conditions, and population needs. Therefore, the present study has supported the broad conclusion reached in prior work that psychosocial interventions can reduce distress in displaced populations, while also refining that conclusion by demonstrating that for displaced women and SGBV survivors, the quality of how care has been delivered has mattered as much as the fact that care has been delivered at all (Nilsson et al., 2008).

Figure 10: Future Research Model for Psychosocial Intervention Effectiveness Among Displaced Women And Sgbv Survivors



A second major finding of this study has been that intervention quality, accessibility, and participation frequency have all significantly predicted distress reduction, although they have not done so with equal force. Intervention quality has emerged as one of the strongest positive predictors, while accessibility and regular participation have also remained significant (Ranjbar et al., 2020). This result has been highly important because it has suggested that displaced women and SGBV survivors have not benefited from psychosocial care in a purely automatic way. Their gains have depended on whether services have been perceived as relevant, respectful, understandable, and sufficiently continuous to build therapeutic benefit over time. That interpretation has matched the broader humanitarian mental health literature. A systematic review and meta-analysis of adult mental health and psychosocial

support programs in humanitarian emergencies concluded that psychosocial interventions can be effective, but it also emphasized substantial heterogeneity across models, settings, and implementation designs, implying that quality and delivery conditions shape the degree of benefit. Likewise, the trial of guided Self-Help Plus among South Sudanese female refugees in Uganda found meaningful reductions in psychological distress, demonstrating that even low-intensity group-based interventions can be effective when structured carefully and implemented at scale (Thompson et al., 2018). The present study has reinforced that line of evidence, yet it has moved beyond simple confirmation by showing that accessibility and participation frequency have remained statistically meaningful alongside quality. In practical terms, this has meant that a woman's psychosocial improvement has depended not only on the therapeutic content of the intervention, but also on whether she has been able to reach the service, understand it, return to it, and remain involved in it long enough for support to accumulate (Turrini et al., 2019). This interpretation has also echoed the critical review of refugee mental health, which argued that post-migration conditions strongly shape psychological outcomes and that interventions must engage the wider life context of displaced populations. Accordingly, the present findings have suggested that program design should not separate technical intervention components from implementation realities. In this study, quality, access, and continuity have worked together as linked conditions of effectiveness. The discussion therefore points toward an integrated reading of psychosocial care, in which clinical usefulness, practical reach, and sustained engagement have all operated as mutually reinforcing drivers of distress reduction (Murray et al., 2014).

The strongest single predictor in the present study has been safe-service trust and survivor-centered care, and this result has carried both empirical and theoretical weight. The high descriptive mean for trust-related items, together with the largest standardized beta in the regression model, has suggested that emotional safety, confidentiality, respect, and non-judgmental listening have been more central to distress reduction than any other service dimension measured in the study. This has been one of the most important contributions of the findings because it has shifted the discussion from the question of whether services exist to the question of how women have experienced those services. The result has strongly paralleled earlier work among women survivors of sexual violence in eastern Democratic Republic of the Congo, where cognitive processing therapy improved not only psychological symptoms but also structural social capital and stigma-related outcomes, indicating that healing in this population is relational as well as emotional (Papini et al., 2018). The present findings have been in the same direction, even though the current study has measured trust and survivor-centered care more directly as service-process variables. The result has also fit squarely within Trauma-Informed Care Theory. It has been argued that trauma-informed care should move from mere treatment toward healing by centering safety, trustworthiness, empowerment, and relational repair, while systematic reviews have found that trauma-informed interventions have often improved PTSD, depression, and anxiety outcomes when delivered with fidelity to those principles (Silove, 2013). In this study, the high explanatory power of trust has suggested that trauma-informed principles have not been abstract ideals; they have been statistically consequential dimensions of intervention success. This has helped explain why some women have benefited more than others even where intervention exposure has been similar. It has also clarified why barriers such as fear of disclosure and stigma have remained damaging: they directly undermine the relational foundation required for recovery. The discussion therefore interprets safe-service trust as the bridge between intervention delivery and meaningful psychosocial change. In the context of displaced women and SGBV survivors, who often enter services carrying histories of violation, silence, and distrust, the capacity of a service to feel safe and survivor-centered has appeared to be the most decisive condition for distress reduction (Turrini et al., 2019).

The findings have also shown that barriers to psychosocial support utilization have significantly reduced intervention effectiveness, and this result has highlighted the importance of interpreting distress through a broader ecological lens. In the current study, barriers such as fear of disclosure, stigma, mobility limitations, and irregular service access have remained moderate at the descriptive level and have shown a significant negative relationship with distress reduction in both correlation and regression analyses. This has meant that psychosocial interventions have worked under constraint rather than in idealized conditions (Purgato et al., 2021). That interpretation has aligned closely with the ecological model of refugee distress, which holds that mental health among displaced populations

arises from both prior war-related violence and ongoing displacement stressors embedded in the social environment. It has also matched arguments that refugee mental health cannot be understood without reference to post-migration determinants such as social exclusion, insecurity, and limited access to services. For women affected by SGBV, the problem becomes even more layered. Research from Lebanon has shown that gender-based violence and mental health difficulties are deeply intertwined among refugee and host-community women engaged in psychosocial programming, while qualitative work on Syrian refugee women and girls has demonstrated that sexual and gender-based violence operates along a continuum across daily life, social roles, and household conditions. The present study has been highly consistent with that literature because it has shown that service barriers have not simply delayed treatment; they have actively weakened psychosocial benefit (Tay et al., 2021). In practical terms, this has meant that programs cannot assume that offering counseling or support groups is sufficient. If stigma prevents disclosure, if transport is insecure, if family restrictions discourage attendance, or if service schedules are unstable, then the therapeutic pathway becomes fragile. The discussion therefore interprets barriers not as background noise but as active mechanisms that suppress intervention effectiveness. This has been a crucial point because it has explained why some women with high trauma burden may still report modest improvement even after service exposure. It has also reinforced the study's broader conclusion that distress reduction in displaced women and SGBV survivors depends on the interplay between intervention content and the conditions under which participation becomes possible (Turrini et al., 2019).

From a practical standpoint, the study has generated several implications for humanitarian mental health and protection programming. The first implication has been that psychosocial support for displaced women and SGBV survivors should be designed as a relationally safe, continuity-oriented service rather than as a one-time response activity. The results have suggested that women have improved most when they have trusted providers, perceived sessions as respectful and confidential, and maintained regular contact with support services. This has meant that programs should invest in provider training that emphasizes trauma-informed communication, non-judgmental listening, confidentiality, and culturally responsive engagement (Khan et al., 2017). Such an implication has been consistent with evidence that cross-cultural trauma-informed approaches improve the capacity of services to respond meaningfully to refugees' mental health needs, and with the broader trauma-informed literature emphasizing healing-oriented rather than symptom-only care. A second implication has been that psychosocial programs should be linked more deliberately with protection, case management, and barrier-reduction strategies (Raja et al., 2015). The present findings have shown that fear of disclosure and stigma continue to weaken outcomes; therefore, interventions that remain psychologically sound but practically inaccessible are unlikely to achieve full impact. This has echoed feasibility work that integrated mental health and intimate partner violence support for refugee women and demonstrated the value of coordinated approaches where distress and violence coexist. A third implication has been that group-based and scalable interventions should not be dismissed as inferior to specialist therapy, provided that relational safety and service quality are preserved. Earlier studies on PM+ and Self-Help Plus have already shown that brief or guided interventions can reduce distress in adversity-affected women and female refugees (Silove, 2013). The present study has supported that practical lesson while adding that service trust appears to be the key condition that determines whether scalability translates into benefit. Therefore, humanitarian agencies should not choose between scale and quality as if they were opposites. Instead, the discussion suggests that the most effective model is one in which scalable interventions are built on trauma-informed relational foundations. In operational terms, that has meant designing services that are accessible, repeated, and trusted, while actively removing social and logistical barriers that keep women from sustained engagement.

The theoretical implications of the study have been equally important because the findings have provided strong support for Trauma-Informed Care Theory while also extending it into a quantitative humanitarian research framework. The theory has been useful throughout the study because it has proposed that recovery from trauma is shaped not only by treatment content but by whether care environments restore safety, trust, voice, and empowerment (Porter & Haslam, 2005). The present findings have directly reinforced that claim. Safe-service trust and survivor-centered care have emerged as the strongest predictors of distress reduction, while intervention quality and accessibility

have also remained significant. This pattern has indicated that the core mechanism of psychosocial improvement has been relational and contextual rather than merely procedural. In that respect, the study has advanced Trauma-Informed Care Theory by showing how its central principles can be operationalized as measurable constructs within a regression model for displaced women and SGBV survivors. The findings have also indirectly converged with the ecological model of refugee distress, which emphasizes that ongoing stressors in the displacement environment shape mental health alongside prior trauma exposure. By integrating trust, barriers, access, and quality into one explanatory model, the present study has shown that trauma-informed care and ecological stress theory are not competing explanations; they are complementary (Silove, 2013). One explains what healing-oriented services should look like, and the other explains why the surrounding environment can strengthen or weaken their effect. At the same time, the discussion has required a revisit of limitations. Because the study has used a cross-sectional design, the findings have supported association more strongly than causal inference. Because the distress change profile has relied on respondents' retrospective perception of pre- and post-intervention experience, recall effects may have influenced the size of reported improvement. Because the data have been self-reported, social desirability and emotional sensitivity may also have shaped responses. Furthermore, the case-study setting has offered depth and contextual relevance, yet it has limited broad generalization across all humanitarian contexts. These limitations, however, have not nullified the study's contribution. Rather, they have clarified the boundaries within which the findings should be read: as strong evidence of patterned relationships between trauma-informed psychosocial service conditions and distress reduction in one defined displaced female population (Vallejo-Martín et al., 2021).

Future research has been especially important in light of these findings, and the present study has suggested several concrete directions that can improve the field. The first proposed direction is a Longitudinal Trauma-Informed Psychosocial Impact Model, in which researchers follow displaced women and SGBV survivors across multiple time points to test how accessibility, quality, trust, and barriers affect distress trajectories over six months, twelve months, and beyond. Such a model would improve on the present cross-sectional design by distinguishing immediate relief from sustained recovery and by clarifying whether trust remains the strongest predictor over time. The second proposed direction is an Integrated Service Pathway Model, in which psychosocial support, protection services, case management, legal referral, and livelihood support are examined together rather than separately. This would respond to the literature showing that violence, mental health, and post-migration stressors are intertwined, and it would allow future studies to test whether combined intervention pathways outperform stand-alone psychosocial services for women with complex trauma and ongoing risk. The third proposed direction is a Barrier-Adjusted Delivery Model, where researchers experimentally compare standard psychosocial care with enhanced care that includes transport assistance, stigma-reduction outreach, confidential referral systems, and flexible scheduling. Given the negative effect of barriers in the present study, such a model could identify which implementation supports most effectively convert service availability into real psychosocial benefit. A fourth direction would be a Trust-Mediated Outcome Model, in which safe-service trust is treated as a mediator between intervention quality and distress reduction. This would test more precisely the theoretical interpretation that quality improves outcomes primarily because it builds trust, and trust then enables disclosure, participation, and therapeutic engagement. Finally, future research should include mixed-methods designs that retain quantitative rigor while also capturing survivors' narratives about why certain services feel safe or unsafe. That approach would be especially valuable because previous studies have shown that refugee women's distress and help-seeking are deeply shaped by social meaning, stigma, and continuity of violence. In sum, future researchers should move toward models that are longitudinal, integrated, barrier-sensitive, and explicitly trauma-informed. That is likely to produce the most meaningful next stage of evidence for improving psychosocial interventions for displaced women and SGBV survivors.

CONCLUSION

This research has examined the role of evidence-based psychosocial interventions in reducing distress among displaced women and survivors of sexual and gender-based violence within a quantitative, cross-sectional, case-study-based framework, and the overall findings have shown that psychosocial

support has had a meaningful and measurable association with improved emotional and psychosocial wellbeing among the respondents. The study has demonstrated that distress among displaced women and SGBV survivors has been deeply shaped by repeated trauma exposure, prolonged displacement, social instability, fear, stigma, and disrupted trust, confirming that psychosocial suffering in this population is multidimensional rather than limited to isolated emotional symptoms. At the same time, the findings have shown that evidence-based psychosocial interventions have contributed positively to distress reduction when women have perceived such interventions as accessible, high in quality, regularly available, and delivered in a safe, respectful, and survivor-centered manner. The results from the descriptive statistics, correlation analysis, and regression model have all pointed in the same direction, showing that safe-service trust and survivor-centered care have emerged as the strongest predictor of distress reduction, followed by intervention quality, accessibility, and participation frequency, while barriers to psychosocial support utilization have reduced the effectiveness of those interventions. These results have confirmed that psychosocial recovery has not depended merely on the existence of intervention programs, but on how women have experienced those programs in practice. The study has therefore reinforced the importance of understanding psychosocial support as both a therapeutic and relational process in which safety, confidentiality, respect, and trust have shaped whether women have felt able to engage, disclose, and benefit from care. The findings have also supported the relevance of Trauma-Informed Care Theory by showing that women have reported the greatest improvement where service environments have reflected the principles of emotional safety, non-judgmental care, empowerment, and dignity. In addition, the results have highlighted that contextual realities such as stigma, disclosure fear, mobility difficulties, and irregular service availability have remained important obstacles that can weaken the potential impact of psychosocial care. Overall, this study has concluded that evidence-based psychosocial interventions are effective tools for reducing distress among displaced women and SGBV survivors, but their full value has depended on the extent to which they have been trauma-informed, accessible, consistent, and responsive to the lived realities of women in displacement settings. In this sense, the study has contributed a structured empirical explanation of how intervention-related factors have interacted with women's psychosocial conditions, and it has shown that meaningful distress reduction has been most likely where supportive services have not only reached women, but have also made them feel safe, respected, and genuinely supported throughout the intervention process.

RECOMMENDATION

Based on the findings of this study, it is recommended that humanitarian agencies, psychosocial service providers, policy actors, and protection-focused organizations strengthen the design and delivery of psychosocial interventions for displaced women and survivors of sexual and gender-based violence by giving greater attention to safety, trust, access, continuity, and survivor-centered care. First, psychosocial services should be delivered through trauma-informed approaches that prioritize confidentiality, emotional safety, non-judgmental listening, and respectful communication, since the findings have shown that safe-service trust has been the strongest predictor of distress reduction. Service providers should therefore receive regular capacity-building training in trauma-informed care, psychological first response, culturally sensitive communication, and survivor-centered engagement so that interventions are not only technically available but also emotionally acceptable to women who have lived through violence and displacement. Second, intervention quality should be strengthened through the use of clear service protocols, appropriate referral mechanisms, structured counseling or support sessions, and supportive monitoring systems that ensure women receive relevant and consistent care over time. Third, access to psychosocial interventions should be widened by reducing physical, social, and informational barriers that discourage participation. This can include establishing decentralized service points, flexible scheduling, community outreach, confidential referral pathways, women-friendly safe spaces, and transportation or mobility support where necessary. Fourth, because participation frequency has shown a positive effect on distress reduction, service providers should aim to improve continuity of care by encouraging repeated engagement, follow-up support, and ongoing psychosocial monitoring rather than one-off contact sessions. Fifth, barriers such as stigma, fear of disclosure, family restrictions, and poor information flow should be addressed through community sensitization, trusted peer outreach, women-led support networks, and awareness activities that

normalize help-seeking and reduce social judgement around psychosocial services. Sixth, psychosocial interventions should be better integrated with protection services, case management, health support, and livelihood or social assistance pathways, since displaced women often experience distress within a broader environment of insecurity and material hardship. Seventh, organizations should adopt data-informed program evaluation systems using tools such as Likert-scale wellbeing assessments, service-quality feedback, and routine monitoring so that interventions can be adjusted based on evidence from women's actual experiences. Finally, researchers and practitioners should work together to create stronger locally adapted psychosocial intervention models that reflect women's cultural realities, displacement conditions, and trauma histories. These recommendations are necessary because the study has shown that psychosocial interventions have been most effective where women have trusted the service, found it accessible, and experienced it as supportive and dignified. Strengthening these areas can improve both the reach and the impact of psychosocial care for displaced women and SGBV survivors.

LIMITATIONS

This study has contributed useful empirical insight into the effectiveness of evidence-based psychosocial interventions for reducing distress among displaced women and survivors of sexual and gender-based violence, yet several limitations have remained important in interpreting the results. First, the study has used a quantitative, cross-sectional design, which has allowed relationships between variables to be measured at one point in time but has limited the ability to make strong causal claims about whether psychosocial interventions have directly caused distress reduction over a longer period. Although the statistical associations have been strong and consistent, the design has not fully captured how distress may change over time or how intervention effects may strengthen or weaken across different stages of recovery. Second, the study has relied on self-reported responses collected through a structured Likert-scale questionnaire, which has made it possible to quantify women's perceptions, but may also have introduced response bias, recall bias, and social desirability bias. Respondents may have underreported or overreported their emotional condition, trauma experience, or service satisfaction due to fear, shame, memory difficulty, or a desire to present themselves in a socially acceptable way. Third, because the study has addressed a highly sensitive topic involving SGBV and psychosocial suffering, some women may have remained hesitant to disclose the full extent of their trauma, distress, or barriers to service utilization, even under confidential conditions. This means that the measured results may not have captured the full depth of psychosocial pain experienced by all participants. Fourth, the case-study-based focus has provided contextual richness and analytical relevance, but it has also limited the generalizability of the findings to all displaced populations, all refugee settings, or all humanitarian intervention environments. Conditions differ widely across camps, host communities, regions, cultures, and service systems, so the findings should be interpreted as most directly relevant to contexts with similar social and service characteristics. Fifth, the sample has been drawn using purposive and convenience considerations within a humanitarian setting, which has improved feasibility and relevance but may have reduced representativeness. Women who were inaccessible, highly isolated, or unwilling to participate may not have been fully reflected in the sample. Sixth, the study has emphasized key intervention-related variables such as accessibility, quality, participation frequency, trust, and barriers, but other potentially important variables such as severity of trauma, provider competence differences, social support networks, legal protection, and economic security have not been explored in equal depth. Finally, the study has interpreted perceived distress reduction partly through retrospective before-and-after self-assessment, which may have been influenced by current emotional state rather than objective longitudinal measurement. These limitations have not invalidated the findings, but they have clarified that the results should be understood within the boundaries of the study design, context, and data collection method.

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