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CHANGES IN MENTAL HEALTH OUTCOMES FOLLOWING PSYCHOSOCIAL SUPPORT AMONG ADOLESCENTS WHO SURVIVED SEXUAL VIOLENCE IN YAOUNDÉ, CAMEROON

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ABSTRACT

Sexual violence during adolescence is associated with substantial psychological consequences, including post-traumatic stress symptoms, depressive symptoms, sleep disturbances, social withdrawal and suicidal ideation. This study assessed changes in mental health outcomes among adolescents who survived sexual violence and received psychosocial support in Yaoundé, Cameroon. A quantitative single-group before–after study was conducted among 60 adolescents aged 10–19 years receiving psychosocial support through the Réseau National des Associations de Tantines (RENATA). Post-traumatic stress symptoms were assessed using the Impact of Event Scale-Revised (IES-R), and depressive symptoms using the Beck Depression Inventory-II (BDI-II). Paired t-tests were used for continuous outcomes and McNemar tests for categorical outcomes. The mean IES-R score decreased from 41.3±8.4 to 22.1±6.3 ($p<0.001$), while the mean BDI-II score decreased from 24.7±7.1 to 13.8±5.8 ($p<0.001$). Sleep disturbances decreased from 81.7% to 33.3%, social isolation from 71.7% to 26.7%, and suicidal ideation from 28.3% to 6.7%. Greater improvement was associated with regular participation in group sessions, satisfactory family support, longer follow-up and earlier access to care. Because there was no control group, the observed changes cannot be interpreted as definitive evidence of a causal intervention effect.

Keywords: sexual violence, adolescents, psychosocial support, mental health, post-traumatic stress, Cameroon.

INTRODUCTION

Sexual violence against children and adolescents is a major public health and human rights concern. Survivors may experience persistent psychological, social and behavioral consequences, including post-traumatic stress symptoms, anxiety, depressive symptoms, sleep disturbances and suicidal thoughts (World Health Organization [WHO], 2017). Evidence from longitudinal and synthesis studies indicates that childhood sexual abuse may have consequences extending into adulthood (Hailes *et al.,* 2019; Dworkin *et al.,* 2017).

Adolescence is a particularly vulnerable developmental period. Exposure to sexual violence may disrupt emotional regulation, interpersonal relationships, family functioning and social integration. In low-resource settings, these consequences may be compounded by stigma, family rejection and limited access to specialized mental health services.

The WHO recommends child- and adolescent-centred, trauma-informed care for survivors of sexual abuse, including attention to safety, confidentiality, psychosocial needs and appropriate referral to mental health services (WHO, 2017). The Inter-Agency Standing Committee also emphasizes integrated mental health and psychosocial support in settings where specialized resources are limited (Inter-Agency Standing Committee [IASC], 2007).

In African settings, social support and coping processes have been shown to be important to the mental health of adolescent survivors of sexual violence. Verelst *et al.,* (2020), for example, highlighted the contribution of social support to mental health outcomes among adolescent victims of sexual violence in Eastern Congo. Nevertheless, evidence concerning community-based psychosocial support for adolescent survivors remains limited in Cameroon.

The objective of this study was to assess changes in mental health outcomes among adolescents who survived sexual violence and received psychosocial support through RENATA in Yaoundé. The primary outcomes were post-traumatic stress and depressive symptom scores, while secondary outcomes included sleep disturbances, social isolation and suicidal ideation.

LITERATURE REVIEW

Sexual violence and adolescent mental health

Sexual violence is associated with a broad range of adverse mental health outcomes. A meta-analysis by Dworkin *et al.,* (2017) demonstrated an association between sexual assault victimization and multiple forms of psychopathology. An umbrella review by Hailes *et al.,* (2019) further documented long-term mental and physical health consequences of childhood sexual abuse.

Psychosocial support and social support

Psychosocial support aims to strengthen psychological well-being and social functioning through interventions such as active listening, counseling, peer support, family support and referral to specialized services. The IASC (2007) recommends layered mental health and psychosocial support approaches, especially in contexts where specialist services are limited.

Among adolescent survivors of sexual violence, social support may influence coping and recovery. Verelst *et al.,* (2020) reported that coping strategies and social support were important factors in the mental health of adolescent victims of sexual violence in Eastern

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Congo. These findings support approaches that combine individual support with family and peer-based interventions.

Cameroonian context
In Cameroon, community and institutional responses to gender-based violence include psychosocial, medical, social and referral services. However, empirical evidence evaluating changes in mental health outcomes following psychosocial support among adolescent survivors remains scarce. Generating local evidence may help inform trauma-informed and contextually appropriate interventions.

METHODOLOGY

Study design and setting

A quantitative single-group before–after study was conducted among adolescent survivors of sexual violence receiving psychosocial support through RENATA in Yaoundé, Cameroon. The study period extended from June to August 2026.

Participants and sampling

Of 113 adolescents initially approached, 60 met the eligibility criteria and participated in the study, corresponding to a participation rate of 53.1%. Participants were aged 10–19 years and had experienced sexual violence. Adolescent assent and informed consent from a parent or legal guardian were obtained where required.

Psychosocial support

The psychosocial support model included reception and active listening, psychosocial assessment, individual psychological support when indicated, peer support through trained “tantines”, group sessions, family mediation and referral to medical, psychological, social or legal services. The approach focused on psychological support, restoration of social functioning and strengthening of family and social support.

Data collection and measures

Post-traumatic stress symptoms were assessed using the 22-item Impact of Event Scale-Revised (IES-R), with scores ranging from 0 to 88 (Weiss & Marmar, 1997). The French version validated by Brunet et al. (2003) was used. An IES-R score ≥33 was used in this study to indicate clinically significant post-traumatic stress symptom severity.

Depressive symptoms were assessed using the 21-item Beck Depression Inventory-II (BDI-II), with scores ranging from 0 to 63 (Beck et al., 1996). The instruments were used to assess symptom severity and were not, by themselves, considered diagnostic instruments.

Behavioral indicators included sleep disturbances, social isolation and suicidal ideation. A pre-test involving 26 adolescents outside the final sample was conducted before the main data collection; no substantive modification of the standardized instruments was made.

Data analysis

Data were analysed using IBM SPSS Statistics. Continuous variables were summarized using means and standard deviations, while categorical variables were summarized using frequencies and percentages. Paired t-tests were used to compare continuous outcomes before and after support, and McNemar tests were used for paired categorical outcomes. Statistical significance was set at $p<0.05$.

Because the study had no control group, observed changes were interpreted as changes associated with exposure to psychosocial support and not as definitive evidence of a causal intervention effect.

Ethical considerations

Ethical clearance was obtained from the Comité Régional d’Éthique de la Recherche pour la Santé Humaine du Centre (CRERSHC) in June 2026 (CE No. 27/18/CRERSHC/2026). Administrative authorization was obtained from RENATA. Confidentiality and anonymity were maintained throughout the study. Participants presenting severe emotional distress or suicidal ideation were managed according to the emergency referral procedure, including contact with the RENATA psychologist when indicated.

RESULTS AND DISCUSSION

Participant characteristics

Among the 60 participants, 52 (86.7%) were female and 8 (13.3%) were male. The largest age group was 14–16 years (27; 45.0%), followed by 10–13 years (18; 30.0%) and 17–19 years (15; 25.0%). Low socioeconomic status was reported for 38 participants (63.3%).

Characteristics of sexual violence

Rape was reported by 31 participants (51.7%), incest or repeated sexual violence by 14 (23.3%), sexual exploitation by 9 (15.0%) and sexual harassment by 6 (10.0%). The perpetrator was known to the survivor in 47 cases (78.3%). Thirty-four participants (56.7%) accessed care within six months of the violence.

Changes in post-traumatic stress and depressive symptoms

The mean IES-R score decreased from 41.3±8.4 before psychosocial support to 22.1±6.3 after support, corresponding to a mean reduction of 19.2 points ($p<0.001$). Significant reductions were observed in intrusion, avoidance and hyperarousal symptoms (all $p<0.001$). The post-support group mean was below the threshold of 33 used in this study; this group-level finding does not establish that every participant was below the threshold.

The mean BDI-II score decreased from 24.7±7.1 to 13.8±5.8, a mean reduction of 10.9 points ($p<0.001$). Thus, the group mean moved from the moderate to the minimal symptom range according to the predefined categories.

These findings are consistent with evidence that sexual violence is associated with adverse mental health outcomes and that psychosocial and social support may contribute to recovery (Dworkin *et al.,* 2017; Hailes *et al.,* 2019).

Behavioral indicators

Sleep disturbances decreased from 49 (81.7%) to 20 (33.3%) ($p<0.001$), social isolation from 43 (71.7%) to 16 (26.7%) ($p<0.001$), and suicidal ideation from 17 (28.3%) to 4 (6.7%) ($p=0.002$). The reduction in these indicators is clinically relevant because they reflect important dimensions of adolescents’ emotional and social functioning.

Factors associated with improvement

Greater improvement was associated with regular participation in at least five group sessions (p=0.007), satisfactory family support (p=0.003), follow-up longer than three months (p=0.011), and access to care within six months (p=0.018). Lesser improvement was associated with social stigma (p=0.009), parental support absence or family rejection (p=0.015), difficulties accessing services (p=0.034), and incest or repeated sexual violence (p=0.021).

The association between group participation and improvement may reflect the importance of peer support and social connectedness, consistent with findings from Eastern Congo (Verelst *et al.,* 2020). Family support was also associated with greater improvement, whereas family rejection and stigma were associated with lesser improvement. These findings reinforce the importance of involving non-offending caregivers when safe and appropriate (WHO, 2017).

Earlier access to care was associated with greater improvement. However, because there was no control group and no multivariable analysis, these factors should be considered associations rather than independent causal determinants.

Strengths and limitations

The study used standardized measures and assessed both psychological symptoms and behavioral indicators. It also provides context-specific evidence from Cameroon.

The principal limitation is the single-group before–after design, which prevents causal attribution of observed changes to psychosocial support. Natural recovery, regression to the mean and concurrent interventions may partly explain the changes. The sample was relatively small and drawn from adolescents receiving support through RENATA, which may limit generalizability. The study also relied partly on self-reported measures. Finally, adjusted effect estimates and confidence intervals were not available for the factors associated with improvement.

CONCLUSION

Substantial reductions in post-traumatic stress and depressive symptom scores, as well as improvements in sleep disturbances, social isolation and suicidal ideation, were observed among adolescents who survived sexual violence and received psychosocial support in Yaoundé.

Regular participation in group sessions, satisfactory family support, earlier access to care and longer follow-up were associated with greater improvement, whereas stigma, family rejection, access difficulties and incest or repeated sexual violence were associated with lesser improvement.

These findings support accessible, adolescent-centred and family-sensitive psychosocial services. However, the absence of a control group prevents causal attribution of the observed changes to the psychosocial support programme. Future controlled longitudinal studies with larger samples are warranted.

AUTHORS' CONTRIBUTIONS

Fabien Memong Ndengue: conceptualization, study supervision, interpretation of findings and critical revision of the manuscript.

Eboutou Mintya Nathalie: data collection, data organization, initial analysis and manuscript preparation.

Both authors approved the final version of the manuscript and agree to be accountable for the work.

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Conflict of Interest

The authors declare no conflict of interest.

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