Breaking the Cycle of Intergenerational Violence:

The Promise of Psychosocial Interventions to Address Children's Exposure to Violence

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About Equimundo:

Equimundo works to achieve gender equality and social justice by transforming intergenerational patterns of harm and promoting patterns of care, empathy and accountability among boys and men throughout their lives. Equimundo has worked internationally and in the US since 2011 to engage men and boys as allies in gender equality, promote healthy manhood, and prevent violence. Previously called Promundo-US, the organization's work was born out of community-based and evidence- based work to engage men and boys in gender equality and nonviolent manhood in numerous settings in Latin America, Asia, sub-Saharan Africa, and North America. To learn more, visit www.equimundo.org.

About Sonke Gender Justice:

Founded in 2006, Sonke Gender Justice is a multi-award winning NGO headquartered in South Africa and working across Africa and globally to strengthen government, civil society, and citizen capacity to promote gender equality, prevent domestic and sexual violence, and reduce the spread and impact of HIV and AIDS. Sonke's vision is a world in which men, women, and children can enjoy equitable, healthy, and happy relationships that contribute to the development of just and democratic societies. To learn more, see: www.genderjustice.org.za.

About Together for Girls:

Together for Girls is a global public-private partnership that works to end violence against boys and girls, with a special focus on ending sexual violence against girls. Founded in 2009, the Together for Girls partnership brings together national governments, UN entities, and private sector organizations to prevent and respond to violence. To do this, the partnership uses a three-pronged model: data, action, and advocacy to promote evidence-based solutions, galvanize coordinated response across sectors, and raise awareness. Currently, Together for Girls works with more than 20 countries around the world. To learn more, visit www.togetherforgirls.org.

About the Global Partnership to End Violence Against Children:

The Global Partnership to End Violence Against Children is a collaboration of over 400 governments, UN agencies, civil society organizations, research institutions, and corporations. The collaboration harnesses the collective energy, expertise, and capabilities of its global network to work for an end to all forms of violence against children, in line with Sustainable Development Goal 16.2. To learn more, visit https://www.end-violence.org/.

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INTRODUCTION

PART ONE

Introduction

Exposure to violence in childhood takes an enormous toll on mental and physical health, future productivity, and perhaps most importantly, on future relationships (World Health Organization [WHO], 2016). Similarly, violence against women can result in long-term physical, mental, social, and economic consequences for women, their children, families, and communities (Ellsberg et al., 2008; WHO, 2013; WHO, 2010). The intergenerational transmission of violence – the link between direct experiences or witnessing of violence in childhood and the increased likelihood of intimate partner violence (IPV) victimization or perpetration (Black, Sussman, & Unger, 2010) – is driven by complex mechanisms. These mechanisms include: (1) unequal gender norms and social learning, and (2) the long-term psychological and physiological consequences of multiple types of direct violence or exposure to violence in childhood.

Exposure to violence in childhood takes an enormous toll on mental and physical health, future productivity, and perhaps most importantly, on future relationships.

The mental health impacts of exposure to violence in childhood underscore the urgent need for mental health and psychosocial support interventions for children,[1] not only to improve their long-term health and well-being but also to prevent future violence in intimate relationships. In spite of the assertion by multiple studies (WHO, 2005; Fulu et al., 2013; Contreras, 2012) that childhood exposure to violence is a key driver of adult IPV against women, there has been little discussion of how psychosocial interventions for children affected by violence might prevent the intergenerational transmission of violence.

Accordingly, this brief focuses on interventions addressing the mental health and trauma outcomes associated with childhood violence as secondary prevention approaches to ending cycles of violence, with special attention to the gendered nature of mental health, relationships, and violence. **In particular, the brief focuses on the evidence base for psychosocial interventions for children and adolescents and the urgent need for the international community to further adopt and scale such interventions in efforts to end the intergenerational transmission of violence.**

It is imperative to note that psychosocial support for children exposed to violence is only one element of a comprehensive suite of services, programs, and policies to respond to, address, and prevent violence against women as well as violence against children, including psychosocial, health, and

[1] "Mental health" and "psychosocial" programming generally refer to the same concepts. Some people assume that "mental health" is related to specific disorders (e.g., post-traumatic stress disorder [PTSD] or depression). However, mental health can also include the positive well-being or functioning of a person's mind, body, and social relationships. "Psychosocial" as a term is more often used in violence prevention and response programming, but it has a similar meaning to mental health. Some may consider psychosocial programs to include more "social" or relationship-focused interventions. However, mental health interventions also often focus on improving one's social relationships. Since these two terms contain significant overlap, this report uses them interchangeably.

safety services for women themselves. Psychosocial support as a violence prevention strategy is at the nexus of the often-siloed fields of violence against women (VAW) and violence against children (VAC). As such, it requires careful attention to the tensions and risks of working across these fields, including to issues of agency, representation, and appropriate legal and protection frameworks.[2] Still, as this brief highlights, it has enormous potential to break cycles of violence and improve the well-being of children and adults around the globe.

Intergenerational Transmission of Violence

> The intergenerational transmission of violence is the link between direct experiences or witnessing of violence in childhood and the increased likelihood of IPV victimization or perpetration.

Increasing attention is being given to the connection between violence against children and IPV (Guedes, Bott, Garcia-Moreno, & Colombini, 2016), particularly the intergenerational transmission of violence (Ehrensaft et al., 2003; Woollett & Thomson, 2016; Richter, Mathews, Kagura, & Nonterah, 2018). While there is also a demonstrated link between experiences of violence in childhood and perpetration of violence against children in adulthood (Crombach & Bambonyé, 2015), this report focuses on future perpetration or experiences of IPV. Research from across the globe indicates that exposure to violence in childhood increases the risk of perpetrating or experiencing IPV in adulthood[3] (i.e., Fulu et al., 2017; Crombach & Bambonyé, 2015; Chiang et al., 2018; Fleming et al., 2015). Evidence further suggests a dose-response relationship, where higher rates of childhood violence are associated with, for example, higher rates of IPV perpetration by men in adulthood (VanderEnde et al., 2016).[4] Children's exposure to violence, unfortunately, may occur in many places: in their family, community, or school or from exposure to civil unrest or conflict (Pinheiro, 2006; WHO, 2016). Although multiple forms of childhood violence are interconnected, this report particularly focuses on violence in the family.

Studies from around the world report a consistent association between exposure to physical, sexual, and emotional violence in childhood and men's adult perpetration of IPV against women (Lee, Walters, Hall, & Basile, 2013; Fleming, 2015; Machisa, Christofides, & Jewkes, 2016; Fulu et al., 2017).

- Analysis of International Men and Gender Equality Survey (IMAGES)[5] data from eight countries (Bosnia and Herzegovina, Brazil, Chile, Croatia, the Democratic Republic of the Congo, India, Mexico, and Rwanda) found that witnessing IPV in childhood was the strongest predictor of physical IPV perpetration by men in adulthood (Fleming, 2015), and similar associations were found in other IMAGES studies from the Middle East and North Africa (El Feki, Heilman, & Barker, 2017).
- The UN Multi-Country Study on Men and Violence in Asia and the

[2] For example, the US, Australia, and Canada have been criticized for "ignoring or even penalizing women seeking protection from spouses, or for accusing women of 'failure to protect' children from abusive partners" (Guedes, et. Al., 2016).

[3] While violence can also occur against men and/or in same-sex relationships, this report specifically focuses on cisgender male-perpetrated IPV against cisgender women in heterosexual relationships.

[4] Experiences of violence in childhood are also associated with perpetration of violence against children in adulthood (see, for example, Crombach & Bambonyé, 2015). However, this report focuses on the link between a history of violence in childhood and future perpetration or experiences of IPV.

[5] IMAGES was developed by Equimundo and the International Center for Research on Women, and it is the largest, most complex study ever on men's and women's practices and attitudes related to gender equality. It has now been undertaken in over 36 countries. This study was built on the pioneering work of the World Health Organization and inspired by the UN Multi-Country Study on Men and Violence.

Pacific found that *all* forms of childhood trauma (physical abuse, sexual abuse, a combination of physical and sexual abuse, emotional abuse, neglect, and witnessing abuse of mothers) were significantly associated with *all* forms of IPV perpetration (Fulu et al., 2013; Fulu et al., 2017).

- Among a sample of 416 adult men in South Africa, 88 percent had been physically abused as children; among these men, 56 percent reported having physically abused their partner, 31 percent of them had sexually abused their partner, and 40 percent were ongoing perpetrators of IPV as adults (Machisa et al., 2016).
- High-income countries also report a similar pattern. In a study from the United States, over two-thirds of men charged with assault of a female partner reported a history of child abuse or exposure to IPV in their family of origin (Lee et al., 2013).

In addition to men's perpetration, exposure to violence in childhood is also a risk factor for women's vulnerability to, and experiences of, IPV from a male partner in adulthood.

Despite the common association across settings, the risk of perpetrating IPV in adulthood may vary depending on the type of violence exposure in childhood. For example, the risk of perpetration was highest for men who experienced physical abuse or sexual abuse in childhood, particularly for those who experienced both physical and sexual abuse (Fulu et al., 2017). Long-term consequences may also vary by the severity or duration of the abuse, and the support received, and indeed many survivors of childhood abuse recover from the trauma and do not use or experience violence in adult relationships.

In addition to men's perpetration, exposure to violence in childhood is also a risk factor for women's vulnerability to, and experiences of, IPV from a male partner in adulthood. A cross-sectional study of women in South Africa found a significant positive association between experiencing violence during childhood and IPV exposure in later life (Jewkes, Levin, & Penn-Kekana, 2002). Throughout the last four decades, studies primarily from the United States have consistently found an association between women's history of sexual abuse by a family member in childhood and rape or attempted rape after age 14 (Montalvo-Liendo et al., 2015; National Center for Victims of Crimes, 2012). This relationship is, however, complex: For example, one prospective study found that child sexual abuse before age 13 was not, by itself, a risk factor for experiencing IPV in adulthood. However, those victimized before 13 and also as adolescents were then at a much greater risk for being a victim of IPV (Siegel & Williams, 2001). Evidence on sexual violence against girls reveals the increased likelihood of depression, post-traumatic stress disorder (PTSD), dissociative symptoms, risk-taking behaviors, and a host of other biopsychosocial outcomes, which increases vulnerability to being targeted by future perpetrators (Trickett, Noll, & Putnam, 2013). Having prior experiences of violence increases the likelihood of future experiences of

violence, making lifetime polyvictimization – unfortunately – more a norm than an exception (Wilkins, Tsao, Hertz, Davis, & Klevens, 2014).

Research also shows that the status of women in society, the learned use of violence to resolve interpersonal conflicts, and men's use of power over women may also contribute to intergenerational violence.

The impact of intergenerational transmission may be further exacerbated in families affected by conflict and displacement. In particular, research shows how conflict, post-conflict, and high-violence settings create multiple forms of trauma, particularly associated with male gender norms, which may compound this intergenerational cycle (Slegh et al., 2012) and makes the provision of psychosocial support all the more urgent.

Across cultural contexts, childhood exposure to violence is linked to the perpetration and experience of IPV in adulthood. Based on this knowledge, there is a clear need to further explore how this evidence can be applied in developing and taking to scale responses to violence against children – and how to embed this understanding within national policies and systems that address both violence against children and violence against women. Such efforts are critical not only for the well-being of children but also to prevent future IPV.

Processes of Intergenerational Violence

Gender norms and social learning

The processes or mechanisms through which the intergenerational transmission of violence occurs are complex. A predominant explanation comes from ***social learning theory***, whereby violence is proposed to be a learned behavior over time (Bandura, 1977). This theory suggests that the family and community environment a child is exposed to helps them develop the normative attitudes and behaviors carried into adulthood (Lee et al., 2013). **These learned behaviors around violence are connected to gender norms and inequalities.** Boys may learn to use violence to demonstrate forms of harmful masculinity and because of internalized attitudes on women's inferiority. For example, studies show that men exposed to IPV in childhood are more likely to display hostility toward women, to have a desire to control them, and to display anger or a negative attitude toward them, increasing men's likelihood of using gender-based violence (Fleming et al., 2015; Lee et al., 2013; Ehrensaft et al., 2003; Schmidt et al., 2007; Cunha & Gonçalves, 2015). Boys can learn these behaviors by observation and also through explicit instruction in the use of violence by perpetrators of violence in the home (Totten, 2000). Research also shows that the status of women in society, the learned use of violence to resolve interpersonal conflicts, and men's use of power over women may also

contribute to intergenerational violence (Jewkes et al., 2002; Ehrensaft et al., 2003). Such mechanisms may be exacerbated in settings of humanitarian conflict. For example, the perceived loss of one's "manhood" during conflict from being unable to protect or provide for one's family may result in men using violence against family members with less power as a means to perform masculinity (Saile, Neuner, Ertl, & Catani, 2013).

Psychological mechanisms

Another mechanism of the intergenerational transmission of violence is the psychological consequences resulting from childhood violence. Boys and girls who have been exposed to or experienced violence have a much higher risk for immediate and long-term mental health issues.[6] Exposure to violence in childhood is associated with a wide range of mental health conditions, including depression, anxiety, PTSD, substance abuse, eating disorders, insomnia, panic attacks, and suicidal ideation (Sachs-Ericsson, Plant, Blazer, & Arnow, 2005). In addition to specific mental health conditions, exposure to violence has also been linked to general psychological difficulties, such as psychosocial or mental distress (which often overlaps with common mental health conditions such as depression or anxiety) and emotion regulation (an inability to manage one's own emotions in response to ongoing and spontaneous demands) (Siegel, 2013). Although most research comes from high-income countries, similar patterns exist and have been found in low-income countries (Contreras et al., 2012). Exposure to early trauma has been shown to impact later mental health through deleterious developmental pathways, such as trauma-manifested avoidance and arousal symptoms (Briggs-Gowan, Carter, & Ford, 2012). A growing body of evidence also suggests prolonged or "toxic" stress from violence and other adverse childhood experiences negatively impacts the developing child's brain architecture and neural connections, resulting in unhealthy stress response and emotional regulation (National Scientific Council on the Developing Child, 2005/2014). Adverse childhood experiences have a profound global impact on children's development, especially for children younger than five (Grantham-McGregor et al., 2007; Black et al., 2017).

"Evidence suggests that the more severe the violence, the more significant the mental health impact and the effect on other domains of functioning.

Evidence suggests that the more severe the violence, the more significant the mental health impact and the effect on other domains of functioning (Gilbert et al., 2009). The long-term impact of violence may vary based on the relationship between victim and perpetrator, the age at which the abuse occurred, and the frequency or severity of the abuse (Kendall-Tackett & Williams, 1993). In addition to the negative effects of direct exposure to

[6] Violence against young children (especially ages birth to three years) results in some of the most devastating long-term effects. However, because psychosocial interventions for children at that age tend to focus on caregivers (i.e., parenting programs) as opposed to children themselves, they were not a focus of this report.

violence, children who regularly witness IPV are almost seven times more likely to develop substantial psychological difficulties compared to their peers (Sturge-Apple, Skibo, & Davies, 2012). Polyvictimization, or exposure to multiple forms of violence on a reoccurring basis, is particularly associated with resulting psychological trauma (Finkelhor, Ormrod, & Turner, 2007). Once a child experiences more than four types of victimization, the impact on mental health significantly increases; those experiencing seven or more types of victimization incur an exponential risk increase (Turner & Hamby, n.d.).

It is important to note, as referenced earlier, that not all children who experience violence develop mental health conditions or go on to perpetrate or experience violence in adulthood. While research on resilience is limited, known reasons that some children demonstrate resilience to violence may be environmental (such as the presence of a supportive adult or caregiver) or internal (such as genetic disposition) protective factors (National Scientific Council on the Developing Child, 2005/2014; Shonkoff et al., 2012). The strong evidence on the increased risk of experiencing psychological consequences from exposure to violence shows the clear need to provide psychosocial interventions to children exposed to violence.

The strong evidence on the increased risk of experiencing psychological consequences from exposure to violence shows the clear need to provide psychosocial interventions to children exposed to violence.

Numerous studies offer insights into the possible pathways between different forms of trauma experienced during childhood and future perpetration of IPV. Research from Asia and the Pacific found that the pathways among men's experiences of childhood maltreatment, witnessing of IPV, and perpetration of physical violence against a partner may be partially connected to alcohol or substance use and a higher number of sexual partners (Fulu et al., 2017). A study of adult men from South Africa found that PTSD symptoms and negative gender attitudes were two factors linking childhood violence (physical, sexual, emotional, and neglect) to the perpetration of IPV (Machisa et al., 2016). **These results suggest the potential value of gender-transformative approaches combined with psychosocial approaches to prevent IPV perpetration and to reduce the psychological consequences of violence, as evidenced by the mediating effects of PTSD in the relationship between childhood trauma and IPV perpetration** (Machisa et al., 2016).

In sum, the literature on the intergenerational transmission of violence and psychological consequences reveals:

- A clear and consistent link between exposure to childhood violence (both witnessing and experiencing) and increased risk for men's future perpetration and women's future experience of IPV.
- A significant body of evidence demonstrating that exposure to

childhood violence often results in poor mental and psychological outcomes and that poor psychosocial functioning and mental illnesses increase the risk of men perpetrating and women experiencing IPV victimization.

- That potential explanations for the intergenerational transmission of violence include both impaired psychosocial functioning and learned harmful gender attitudes and behaviors.
- That the field of violence prevention should consider the long-term benefit of psychosocial interventions for children and their caregivers, teachers, and communities, combined with gender-transformative interventions, as a means to prevent future IPV.

A large body of evidence exists on childhood psychosocial interventions in response to trauma, yet these programs have largely been implemented and evaluated in high-income countries. Furthermore, these programs typically fall within the "response" side of violence programming. Few to none have also evaluated the long-term evidence of psychosocial programs as potential prevention of adulthood IPV.

PART TWO

INTERVENTIONS AND EVIDENCE

Interventions and Evidence

This section outlines examples of psychosocial interventions for children or adolescents. The interventions are drawn from both the peer-reviewed literature and program reports and include those with strong evidence, such as results from randomized controlled trials, as well as those with promising evidence from quasi-experimental or qualitative evaluations. However, only interventions presented in the English-language literature are included. The interventions presented come from a variety of settings and countries, with a particular focus on those from the Global South. Some effective interventions from high-income countries with the potential for adaptation to low- or middle-income countries are also presented. Several interventions include a focus on the use of psychosocial approaches in conflict-affected/humanitarian settings.[7]

Given the multiple potential psychosocial problems resulting from trauma (such as PTSD, depression, anxiety, conduct disorders, and general distress), the included interventions cover a variety of outcomes, and some combine elements of more than one intervention and/or address multiple outcomes.[8] The interventions target children or youth who have experienced a range of traumatic events, including sexual abuse, witnessing of violence, or exposure to war. However, not all studies presented are from explicitly trauma-affected populations, although they do demonstrate the evidence of potentially important interventions to address varied psychosocial outcomes that are known to be potential consequences of trauma. **The interventions included were mostly not intended to reduce violence perpetration or victimization but rather to improve mental health outcomes for children exposed to violence**; thus, the outcomes on violence are usually not available, with some exceptions. For this reason, interventions explicitly focusing on violence prevention (such as parenting/child abuse prevention programs, school bullying prevention, sexual assault prevention, or adolescent IPV prevention) that do not have a psychosocial component are not included.

[7] A recent systematic review and individual participant data meta-analysis evaluated focused psychosocial interventions for children in low-resource humanitarian settings (Purgato et al., 2018). The study included data from 3,143 children recruited to 11 randomized controlled trials, and it identified a beneficial effect of focused psychosocial support interventions on PTSD symptoms and functional impairment. The studies did not report a significant positive effect on anxiety or depression symptoms (Purgato et al., 2018). Many of the most promising interventions from the study are included in this report.

[8] A limitation in the study of global mental health is that most measurement is based on diagnostic criteria developed for Western populations or populations in the Global North. While significant work has been done on developing or adapting measures across cultures, gaps remain in understanding the cultural expressions of psychosocial symptoms and disorders. Further, diagnostics are also usually gender-blind and may lack nuance in gendered differences in psychological conditions.

INTERVENTIONS FOR ADULTS WITH A HISTORY OF CHILDHOOD VIOLENCE

This report focuses on psychosocial programs for children and adolescents, as addressing the psychological consequences of trauma early in life can have long-lasting impacts on their future lives. However, it is important to note that a range of psychosocial interventions for adults with a history of childhood violence also exist and deserve consideration (Jong et al., 2014). For example, Living Peace is a program in the Democratic Republic of the Congo that provides psychosocial support and group education to men and their partners in post-conflict settings to address the effects of trauma and to develop positive, nonviolent coping strategies. The final section returns to the considerations of adult interventions.

Much of the evidence presented here is from interventions implemented for individuals; however, many of the interventions include individual and group components, and some systemic approaches are also discussed. **While not intended to be a systematic review or comprehensive list of interventions, the following sections highlight *examples* of interventions with strong evidence or potential for low-resource settings.** The interventions are organized into four sections, based on their level of delivery: Individual or Group, Family, School, or Community.

LEVELS OF CHILD AND ADOLESCENT PSYCHOSOCIAL INTERVENTIONS	
Individual	Delivered one-on-one with a child or adolescent and a facilitator.
Group	Delivered with small groups of children or adolescents and a facilitator. Some interventions have evidence for delivery with individuals or groups.
Family	Include at least two family members (for example, a child and a caregiver). Some family-based interventions also have evidence for delivery in a group format, with multiple families participating together.
School	Delivered in school settings. They may include individual or group-level interventions, but delivered in a school setting. Some may also target entire school student populations.
Community	Target all children (and possibly caregivers/adults) in a community.

Individual and Group Interventions

Cognitive behavioral therapy with a trauma focus

The psychosocial intervention with the most evidence for children (ages three to 18) with a history of violence or trauma is cognitive behavioral therapy with a trauma focus. It was developed as an evidence-based treatment approach (based on traditional cognitive behavioral therapy [CBT]) for traumatized children; it is a flexible, components-based treatment model made up of individual child and non-offending parent sessions, as well as joint non-offending parent-child sessions (Cohen & Mannarino, 2008). Exposure to traumatic events (a distressing or frightening event or series of events) can result in a variety of emotional and behavioral symptoms displayed in children and adolescents. Emotional problems may include sadness, anxiety, fear, or anger, as well as difficulty controlling or regulating emotions (Cohen & Mannarino, 2008). Behavioral problems may be displayed through avoidance of trauma reminders, as avoidance is a hallmark of PTSD (Cohen & Mannarino, 2008). Cognitive problems may present themselves as distorted ideas of why traumatic events happened or who was responsible (feelings of self-blame), feelings of shame or worthlessness, and/or an erosion of trust in others (Cohen & Mannarino, 2008), many of which lead to adulthood use of violence.

Key components of the approach are summarized using the acronym PRACTICE:

- Psychoeducation;
- Parenting skills;
- Relaxation skills;
- Affective modulation skills (increasing emotional expression through a variety of feeling games);
- Cognitive coping skills (recognizing connections between thoughts, feelings, and behaviors in everyday situations);
- Trauma narrative and cognitive processing of traumatic events (creating a narrative of what happened during the traumatic event to overcome avoidance, prevent cognitive distortions, and provide context to a child's traumatic events in a larger framework);
- In vivo mastery of trauma reminders (by developing a gradual exposure to trauma cues that trigger avoidance);
- Conjoint child-parent sessions (to allow for communication to shift from the child talking about traumatic experiences with the therapist to sharing with the parent); and
- Enhancing safety and future development trajectory (practicing skills tailored to the situation of each child and family during individual or parent-child sessions – for example, domestic violence safety plan development) (Cohen & Mannarino, 2008).

Leenarts and colleagues (2013) conducted a systematic review of studies on evidence-based treatment for children with trauma-related psychopathology as a result of a wide range of experiences (primarily interpersonal sexual or physical violence, but also including exposure to other traumas such as motor vehicle accidents, terrorist attacks, war, or disaster). The review included 26 randomized controlled trials and seven non-randomized controlled clinical trials on psychotherapeutic interventions for children with trauma-related psychopathology. Results of the systematic review, which included studies from 2000 to 2012, indicated CBT with a trauma focus as the best-supported treatment option for youth with a history of trauma. Regardless of the length and potential inclusion of a trauma narrative component, CBT with a trauma focus improved children's symptomatology and safety skills, and enhanced parenting skills.

A growing body of evidence demonstrates the effectiveness of CBT with a trauma focus in the Global South, including in Zambia, Uganda,

and the Democratic Republic of the Congo. Murray and colleagues (2015) evaluated the approach for trauma-affected orphans and vulnerable children in Zambia. In a randomized clinical trial involving 257 children, they found CBT with a trauma focus to significantly reduce trauma and stress-related symptoms and functional impairment[9] when compared to the treatment usually offered in services for orphans and vulnerable children (Murray et al., 2015). When compared to other trials of CBT with a trauma focus in high-resource settings such as the United States and Norway, the study conducted in Zambia had large effect sizes (Murray et al., 2015). The authors point to the generalizability of their findings, noting there were few exclusion criteria and a wide array of trauma experiences among the orphans and vulnerable children (Murray et al., 2015). Additional studies from Uganda and the Democratic Republic of the Congo have focused on testing CBT with a trauma focus for PTSD symptoms among child soldiers and other war-affected children, a population that presents high levels of PTSD and mistrust (Ertl, Pfeiffer, Schauer, Elbert, & Neuner, 2011; McMullen, O'Callaghan, Shannon, Black, & Eakin, 2013). Ertl and colleagues (2011) assessed the feasibility and efficacy of a community-based intervention targeting PTSD in formerly abducted boys (aged 13 to 17) in Uganda. For this study, participants were randomized into three treatment groups – narrative exposure therapy (derived from CBT with a trauma focus), an academic catch-up program with elements of supportive counseling, and a waitlist – and were assessed for symptoms of PTSD, depression, and related mental health conditions. Compared to the other two groups, the narrative exposure/therapy group experienced PTSD symptom reduction, lower rates/scores of depression, and reduced suicidal ideation and feelings of guilt, as well as decreased stigmatization, all essential to readjustment to society for former child soldiers (Ertl et al., 2011).

CBT with a trauma focus has also demonstrated effectiveness in group settings, which may be more feasible and/or acceptable in low-resource settings. Two randomized controlled trials in the Democratic Republic of the Congo evaluated a group-based approach: one with 50 war-affected boys aged 13 to 17, including some former child soldiers (McMullen et al., 2013), and one with 52 war-affected girls aged 12 to 17 exposed to sexual violence (O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013). Participants from both studies received a 15-session, group-based culturally modified CBT with a trauma focus. In addition, three short sessions were held for available parents of children in treatment and control groups; these sessions described the impact of trauma on youth, explained the intervention, and facilitated training on child protection and children's rights by a local non-

[9] Functional impairment is the extent to which an individual is unable to function in their daily life activities.

governmental organization (McMullen et al., 2013). The study with boys found significant reductions in post-traumatic stress symptoms, overall psychosocial distress, depression- and anxiety-like symptoms, and increased prosocial behaviors, for participants in the group-based therapy. The study with girls found a significant reduction in trauma symptoms, symptoms of depression and anxiety, conduct problems, and increased prosocial behaviors (O'Callaghan et al., 2013).

Interpersonal psychotherapy (IPT)

Another group psychosocial intervention with broad empirical support is interpersonal psychotherapy (IPT). IPT was originally developed in the United States for individuals and is a brief, time-limited (12-session), manualized psychotherapy intervention; there are over 90 clinical trials from multiple continents supporting its effectiveness in treating a range of psychiatric diagnoses, including depression, anxiety, PTSD, and borderline personality disorder. **The premise of IPT is that depression, for example, occurs in a social context regardless of its cause** (WHO & Columbia University, 2016). IPT focuses on helping participants deal with social struggles, which can all be categorized into one of four areas:

- Resolving conflict in significant relationships;
- Coping with grief after the loss of a loved one;
- Overcoming difficulties in adapting to changes in relationships or life circumstances; or
- Gaining an ability to handle difficulties from social isolation.

> Youth Readiness Intervention participants reported significantly better emotion regulation, less functional impairment, and more prosocial behaviors compared to the control group.

To address these areas, participants learn and practice relationship skills with the goal of reducing symptoms and improving life functioning. IPT for depressed adolescents (IPT-A) was adapted from IPT (Mufson, Dorta, Moreau, & Weissman, 2004).

CBT and IPT-A have the largest amount of evidence amongst evaluated programs for the reduction of depression symptoms among adolescents; however, IPT-A has been found to have stronger benefits over time (Zhou et al., 2015). In a study of IPT-A use with war-affected youth in northern Uganda, Bolton and colleagues (2007) randomized 314 adolescents to one of three conditions: group IPT, a creative play intervention, and a waitlist control group. Girls in the IPT groups showed statistically significant improvement in depression scores compared to the control group. While boys' depression

scores improved, the changes were not statistically significant. The creative play intervention showed no effect on depression. The group format of IPT and the focus on coping with interpersonal problems through group discussion were found to be culturally relevant and reduced stigma among adolescents in northern Uganda. Additionally, IPT for adult groups is being delivered in Ugandan communities and neighborhoods by the organization Strong Minds, which has recently started community- and school-based delivery for adolescents.

As another example, a group intervention with war-affected youth in Sierra Leone (the Youth Readiness Intervention) combined aspects of IPT and CBT, such as discussing the effects of trauma and psychoeducation, to assess mental health symptoms and functional impairment. Betancourt and colleagues (2014) randomized war-affected youth by sex and age to a control group or to the Youth Readiness Intervention, which was delivered by locally trained counselors. After treatment, youth were again randomized and offered an education subsidy immediately or waitlisted. Youth Readiness Intervention participants reported significantly better emotion regulation, less functional impairment, and more prosocial behaviors compared to the control group (Betancourt et al., 2014). However, there was no significant improvement in terms of psychological distress or post-traumatic stress symptoms (Betancourt et al., 2014). At the six-month follow-up, the difference in symptom improvement was no longer significant, although Youth Readiness Intervention participants had greater school attendance and improved classroom behavior compared to control group participants (Betancourt et al., 2014). Participants who received the educational subsidy were six times more likely to persevere in school, but there were no additional effects on mental health symptoms (Betancourt et al., 2014). In contrast, the Youth Readiness Intervention produced multiple and long-term emotional and behavioral benefits, proving more effective than financial support for education alone (Betancourt et al., 2014).

Mindfulness and yoga approaches

Originating from Eastern traditions, yoga and mindfulness as interventions for trauma are receiving increasing attention and evaluation. Burgeoning literature on mindfulness-based interventions shows their potential for use with children and adolescents, particularly for stress, anxiety, and depressive symptoms (Kallapiran, Kirubakaran, Koo, & Hancock, 2015). Mindfulness-based interventions are typically brief (around eight sessions), are group-based, and include meditation. Types of mindfulness-based approaches that have demonstrated the most promising effects with

youth include mindfulness-based stress reduction and acceptance and commitment therapy (Vujanovic, Niles, Pietrefesa, Potter, & Schmertz, n.d.). For adults with a history of childhood sexual abuse, Earley and colleagues (2014) reported a statistically significant decrease in PTSD, anxiety, and depression symptoms among a sample of 19 adult survivors in an eight-week mindfulness meditation-based stress reduction program, with improvements maintained at the 2.5-year mark.

Growing evidence supports the use of yoga as a treatment for depression and PTSD among child or adolescent survivors of sexual assault and abuse (van der Kolk, 2014; La Schiava, Moorhead, Stich, Toren, & Vang , 2016). Yoga may be a particularly relevant intervention with trauma survivors because yoga allows survivors to regain bodily awareness after the common PTSD symptom of physical dissociation (van der Kolk, 2014; La Schiava et al., 2016). In a study in postwar Kosovo, adolescents with PTSD symptoms were randomly assigned to a 12-session mind-body group program or to a waitlist control group (Gordon, Staples, Blyta, & Bytyqi, 2008). The groups were led by high school teachers, in consultation with psychiatrists and psychologists. The intervention included meditation, guided imagery, and breathing techniques; self-expression through words, drawings, and movement; autogenic training and biofeedback; and genograms. Compared to the control group, adolescents in the mind-body intervention reported lower PTSD symptom scores, and reductions were maintained at the three-month follow-up (Gordon et al., 2008).

Common Elements Treatment Approach

Given the relationship between violence and multiple psychiatric diagnoses, a move toward "transdiagnostic" approaches (or programs that seek to simultaneously address several mental health areas) may prove particularly relevant. The Common Elements Treatment Approach is an ongoing transdiagnostic mental health intervention that was developed for trained non-professionals to deliver in low- and middle-income countries; the approach has demonstrated significant effects on a range of mental health symptoms among adults (Bolton et al., 2014; Weisz et al., 2015). This modular and flexible approach teaches CBT elements common to evidence-based treatments for trauma, anxiety, depression, and behavioral problems (Kane et al., 2017). A randomized controlled trial conducted in Zambia evaluated the approach's effectiveness with mothers, fathers, and children in terms of reducing violence against women and girls and decreasing alcohol abuse in families; eligibility criteria included the experience of moderate to severe partner violence against women and hazardous alcohol abuse

by their partners (Kane et al., 2017). For this trial, the Common Elements Treatment Approach was adapted to include a CBT-based substance use reduction component; typically, this type of component includes any of, or a combination of, the following: motivational enhancement strategies targeting ambivalent attitudes about behavior change, contingency management approaches, and/or relapse prevention (Kane et al., 2017). The study's primary outcome was violence prevention as measured by the Severity of Violence Against Women Scale, and it is part of the What Works consortium of studies conducted in Africa, Asia, and the Middle East (Kane et al., 2017). Study findings indicate that the intervention significantly reduced women's experience of sexual and non-sexual IPV over a sustained period of time, decreased both women and men's use of alcohol, and improved other mental health conditions (The Prevention Collaborative, 2019).

> The approach has demonstrated significant effects on a range of mental health symptoms among adults.

Risk Reduction through Family Therapy

In an effort to address multiple psychological conditions experienced by survivors of childhood sexual assault, Danielson and colleagues (2012) developed an integrated treatment called Risk Reduction through Family Therapy, which integrates principles of multi-systematic therapy with CBT with a trauma focus and psychoeducation strategies aimed at preventing high-risk sexual behavior (Danielson et al., 2012). Risk Reduction through Family Therapy is guided by an ecological theory that adolescents are influenced by multiple social and environmental factors, including family, school, peer networks, and community, and it adopts a family-based approach to intervention and allows therapists to intervene in multiple social systems. In a randomized clinical trial of Risk Reduction for Family Therapy (the programmatic and clinical name for the program) among adolescents with a history of childhood sexual abuse in the United States, adolescents experienced a significant reduction in substance use and improvements in substance use risk factors; participants in both Risk Reduction for Family Therapy and treatment as usual (TAU) had reductions in PTSD and depression symptoms, with significantly greater differences in parent-reported PTSD, depression, and internalizing symptoms among Risk Reduction for Family Therapy-condition youth. A significant limitation in interpreting the findings of this study, however, is that despite a rigorous randomization process, baseline differences between the two groups existed (Danielson et al., 2012). **These types of family interventions are not recommended for use with a child and a family member who perpetrated violence (e.g., offending caregiver or offending sibling). Thus, such interventions are more appropriate when the type of violence experienced by the child or adolescent resulting in psychological consequences is by a non-family member perpetrator.**

Child and Family Traumatic Stress Intervention

The Child and Family Traumatic Stress Intervention is a brief (with an average of four sessions) intervention for a child and their caregiver to be implemented within 30 to 45 days of a traumatic event or disclosure of physical or sexual abuse (Berkowitz & Marans, 2011). The intervention's objective is to improve communication between the child and their non-abusive caregiver to increase the caregiver's support of the child and to teach specific skills to both the child and caregiver on coping with the traumatic experience. The program has demonstrated evidence of impact with multiple ethnic groups and predominately lower-income families in the United States. The intervention's goal is to prevent the onset of PTSD, and in a randomized trial, it reduced PTSD symptoms by 69 percent among children aged seven to 17 (Berkowitz, Stover, & Marans, 2011).

School Interventions

Schools provide another programming opportunity for addressing childhood trauma. CBT with a trauma focus has been effectively delivered in schools (cognitive behavioral therapy for use in schools, or CBITS) (Leenarts et al., 2013), and it is an important consideration for targeted, school-based interventions for children experiencing elevated trauma symptoms. This section presents additional school-based programs for trauma-affected children, including interventions evaluated in the Global South and promising ones from the Global North.[10] It also describes examples of universal school-wide interventions focused on mental health promotion, as well as the opportunity to integrate mental health promotion into universal school-based violence prevention interventions.

[10] Another robust area of programming is social-emotional learning interventions. These programs generally focus on all children as opposed to those who have a specific history of violence or trauma. While these programs were not a focus of this report, some evidence suggests their differential role for those with or without a history of violence and, thus, they are worth further consideration.

CASE STUDY: YOUTH LIVING PEACE AND EXPECT RESPECT

Youth Living Peace was implemented between 2015 and 2017 in Brazil and the Democratic Republic of the Congo and focused on preventing and responding to sexual and gender-based violence against adolescent girls (aged 13 to 19) in post-conflict and high-urban violence settings. The intervention aimed to help adolescents heal from experiences of violence and to provide school-based training for violence prevention. Group education activities, as well as individual and group therapy, focused on changing attitudes around gender equality, the use of violence, and self-efficacy in relationships. Other activities included school-wide campaigns and advocacy with key stakeholders in schools, government, and civil society organizations on policies and programming to prevent and respond to violence against adolescents. The project was coordinated by Equimundo and implemented by HEAL Africa and the Living Peace Institute in the Democratic Republic of the Congo and by Instituto Promundo in Brazil, with support from the UN Trust Fund to End Violence Against Women.

After three years of implementation, an external evaluation found the approach to be effective and appropriate for addressing participants' experiences, knowledge, attitudes, behaviors, and responses related to violence against women and girls, as well as for positively impacting a broader group of stakeholders. The Youth Living Peace experience highlighted the need to set up systems to address adverse events and carefully monitor implementation in a vulnerable population. Selected key findingsfr om the report include:

SELECTED IMPACT IN BRAZIL

- Participants demonstrated increases in knowledge and the ability to **navigate issues related to gender**; **increase in empathy and nonviolent communication; deconstruction of harmful masculine norms**; improved attitudes on sex and consent; and greater acceptance of same-gender attraction.
- Girls who participated experienced a **28% decrease in being insulted or humiliated** in the last three months, and boys who participated experienced a **37% decrease in verbal and psychological violence**.
- Teachers were more likely to **report a case of abuse** to the appropriate external bodies (child protection unit/social services), from 88% at pre-test to 100% at post-test.
- Educational staff and partners from local government (NIAP – Interdisciplinary Centre for the Support for Schools) **improved development and deconstruction of gender norms.**

SELECTED IMPACT IN THE DEMOCRATIC REPUBLIC OF THE CONGO

- Adolescents developed a greater ability to gain control over and improve their lives, **denounce acts of violence, take action**, and increase social support through solidarity.
- Girls experienced **more self-confidence** and more opportunities to play active roles at school.
- 63% of participants in the pre-test reported tense relationships with their parents; in post-test, **100% of adolescents had begun to ask them about sexuality, relationships, and family plans.**
- Community members supported the **efficacy and need for expansion of the project.**
- The Ministry of Education uses Youth Living Peace to operationalize the Division of Primary, Secondary, and Vocational Education's plans to **address gender issues, reproductive health, and sexuality.**

The program incorporates ideas from several sources: Equimundo's Program H (adapted in 34 settings), which is designed for young men to encourage critical reflection about rigid norms related to manhood and about the transformation of stereotypical roles associated with gender; Living Peace, a program that provides psychosocial support and group education to men and their partners in post-conflic t settings to address the effec ts of trauma and to develop positive, nonviolent coping strategies; and a US-based intervention, Expect Respect. In a non-randomized controlled evaluation with over 1,600 participants in 36 US schools, Expect Respect program participants reported reductions in reactive and proactive aggression and in perpetration and victimization of teen dating violence (Reidy, Holland, Cortina, Ball, & Rosenbluth, 2017). Other evaluations demonstrated improved healthy conflic t resolution behaviors (Ball et al., 2012).

Classroom-based intervention

The classroom-based intervention (CBI) is a manualized group approach for children who have been exposed to traumatic events, including but not limited to violence. The intervention incorporates both prevention and treatment aspects and is delivered in 15 sessions over five weeks. CBI includes cognitive-behavioral techniques (such as trauma-processing activities) and creative-expressive elements (such as drama, movement, and music). Evaluations of CBI have shown a range of outcomes. The strongest evidence for CBI came from a study in Indonesia by Tol and colleagues (2008), which involved a cluster randomized trial of CBI at the school level for 495 conflict-exposed children; seven schools were randomized to the intervention and seven to the waitlist, and assessments occurred at baseline, one week after the intervention, and six months after the intervention. A significant reduction in PTSD symptoms and increased maintained hope was recorded among children in the intervention group; no significant changes were found in depressive and anxiety symptoms or in functional impairment between groups (Tol et al., 2008). Additional studies on CBI have demonstrated mixed results, depending on factors such as sex, level of traumatic stressors, age, and household size (Jordans et al., 2010; Tol et al., 2012; Tol et al., 2014). One study on CBI even found an unexpected harmful effect on PTSD symptoms for girls (Tol et al., 2012). Despite mixed findings on CBI, there are potentially positive lessons learned or uses of this program. For example, CBI may be most effective in contexts with generally supportive families and low exposure to ongoing conflict-related violence. Perhaps CBI is most effective in situations where war conflict has lessened and children are not highly affected by conflict in their own home.

POD and POD Adventures

POD is a transdiagnostic problem-solving intervention for adolescents with elevated mental health symptoms and associated impairment. The intervention was developed for delivery by non-specialist school counselors to individual students, and it is currently being evaluated in government-run secondary schools in New Delhi, India (Parikh et al., 2019). The intervention engages students to apply a structured problem-solving strategy following three steps: problem identification, option generation, and do it (Parikh et al., 2019). Results from a forthcoming trial will assess adolescent impairment, perceived stress, mental well-being, and clinical remission. POD Adventures is an adaptation of POD that uses a blended approach involving face-to-face intervention delivery with a smartphone-delivered game (Gonsalves et al., 2019). This adaptation highlights the potential for technology-assisted mental health or psychosocial interventions to address the mental health needs of young people in low-resource contexts. Both POD and POD Adventures were developed as part of a comprehensive suite of transdiagnostic interventions for use in Indian secondary schools (Parikh et al., 2019).

Universal school approaches

Trauma-informed schools

In the United States, increasing attention is focusing on the development of "trauma-informed" or "trauma-sensitive" schools (Chafouleas, Johnson, Overstreet, & Santos, 2015). Although this model has yet to be applied (to the authors' knowledge) in low-income countries or with conflict-/war-affected populations, it has been used in low-income communities in the United States where children are often exposed to compounding factors of child abuse, community violence, and poverty. One example is the Healthy Environments and Response to Trauma in Schools (HEARTS) program, which is a total (that is, universal) school approach. HEARTS is a multi-tiered approach that focuses on changing school culture to be trauma-sensitive, staff to be trauma-informed in their interaction with students, and interventions to be geared toward children who have suffered varying degrees of trauma (Dorado, Martinez, McArthur, & Leibovitz, 2016). The HEARTS program has seen success, as measured by an interruption in the "school-to-prison" pipeline, overall increased wellness in at-risk communities, and overall student success academically and emotionally (Dorado et al., 2016). In general, however, more research is needed on trauma-informed schools and on their potential to improve overall psychosocial functioning of children, especially in conflict-affected communities and other global settings.

SEHER

SEHER, meaning "dawn" in Hindi, is a multi-component, whole-school health promotion intervention implemented in government-run secondary schools in Bihar state, India (Shinde et at., 2018). The intervention includes content on hygiene, bullying, mental health, substance use, reproductive and sexual health, gender and violence, rights and responsibilities, and study skills. Whole-school activities include a School Health Promotion Committee; awareness-raising through skits, role plays, and discussions; a letterbox platform for children to voice their concerns; and a wall magazine to build knowledge on themes for the month (Shinde et al., 2018). The intervention also includes peer groups, workshops, and available individual counseling for self- or teacher-referred students. A cluster randomized trial with 13,035 ninth grade participants at baseline and 14,414 at endline demonstrated the effectiveness of SEHER delivered by a lay counselor (compared to a control condition) in terms of school climate, depression, bullying, violence victimization, attitudes toward gender equity, and knowledge on reproductive and sexual health. Baseline data were collected at the start of the academic year, and endline data were collected eight months later at the end of the academic year. No significant differences were found, compared to a control condition, for SEHER delivered by teachers (Shinde et al., 2018).

What is relatively clear is that more research is needed on school-based interventions, including on multi-tiered approaches (meaning both school-wide programming and targeted programming for students with greater needs). Many school-based interventions in low- and middle-income countries have focused on school-wide mental health promotion, with positive effects for mental health and educational attainment (Fazel et al., 2014). Some studies in the United States also show a link between lower student-to-school-counselor ratios and better graduation rates and lower rates of both suspensions and disciplinary incidents (Lapan et al., 2012). However, more implementation and evaluation research is needed on effective school-based prevention or treatment interventions to reach children with greater psychosocial needs (Fazel et al., 2014). SEHER in India is an example of a promising intervention combining a whole-school approach with access to targeted treatment for students with greater needs. SEHER highlights that the potential exists, for example, for violence prevention and/or physical health promotion school programming to integrate in mental health activities for enhanced effectiveness.

Community-Wide Interventions

While the majority of evidence-based psychosocial interventions (necessarily) target children or adolescents with elevated symptoms, community-wide interventions may complement targeted interventions. Similar to entire-school interventions, entire-community interventions are also likely to be insufficient for children with the greatest needs. **Where community-level interventions may be critically helpful is in creating safe, nurturing environments for positive child development and a supportive**

community culture. Such environments may also promote a non-stigmatizing environment for delivering more targeted services. It is also important to note that most of the individual-level interventions discussed earlier have been delivered in community settings (as opposed to mental health hospitals, for example).

Child-friendly spaces

Child-friendly spaces are safe spaces set up in the aftermath of humanitarian disasters or conflict. They are available to all children in a community, regardless of how impacted they have been by the conflict/disaster or other types of potential trauma. These spaces vary from place to place but typically include activities for children such as games, sports, drama, informal learning opportunities, and referrals to other needed forms of support. **Evaluation evidence on child-friendly spaces shows overall positive trends in terms of psychosocial well-being for children** (Metzler, Savage, Yamano, & Age, 2015). O'Callaghan and colleagues (2013) conducted a randomized controlled trial comparing child-friendly spaces to CBT with a trauma focus for 50 war-affected Congolese youth exposed to multiple adverse life events (for example, 100 percent were exposed to gunshots or explosions, 88 to 92 percent witnessed murder or killings, and 31 to 33 percent witnessed parental IPV). Both interventions were conducted in a structured, group-based format over nine weeks. The study found that both child-friendly spaces and CBT with a trauma focus were effective in reducing post-traumatic stress symptoms, internalizing symptoms, and conduct problems at six-month follow-up, with no differences between the two interventions. The child-friendly spaces intervention evaluated in this particular study included a structured set of eight modules on topics including avoiding potential unsafe settings, sexually transmitted infections, child rights, identifying personal skills and social supports, overcoming life challenges, and acting out ways to protect oneself as a young person.

Ahlan Simsim, or Welcome Sesame, is a major new collaboration between the Sesame workshop and the International Rescue Committee to support children exposed to trauma in Syria, Jordan, Lebanon, and Iraq. It includes safe spaces as well as media (a new version of "Sesame Street"), parenting support, and advocacy components. Learning from this initiative will make an important contribution to the field.

However, evidence on child-friendly spaces is mixed across contexts, due largely to the variability in their implementation across settings and the complexity of researching community-wide humanitarian programming (Metzler et al., 2015). Child-friendly spaces have been shown to have stronger impacts on younger children and in places where psychosocial programming is more strongly emphasized (Metzler et al., 2015). Despite variability in implementation and effects, though, child-friendly spaces are one of the few community-wide interventions aimed at promoting

psychosocial well-being for children affected by trauma. More needs to be learned about these programs, especially in terms of exploring what specific components or structure is needed for child-friendly spaces to be most effective.

A NOTE ON MENTAL HEALTH PROMOTION INTERVENTIONS AND RESILIENCE

Mental health promotion interventions for children and adolescents aim to increase overall well-being and provide a foundation for positive development and good mental health (Barry et al., 2013). Influenced by the field of positive psychology, mental health promotion interventions typically focus on broad populations of children. Still, in settings where violence against children is widespread, these interventions at a community-wide level may have an important role in promoting resilience and preventing the development of psychological problems (Barry et al., 2013). A systematic review of the effectiveness of mental health promotion interventions for young people in low- and middle-income countries showed the effectiveness of these interventions in promoting positive outcomes (such as coping, hope, and self-esteem) and preventing negative outcomes (such as depression and anxiety). Similar approaches focus on resilience and/or social-emotional learning. Mental health promotion interventions can be beneficial in the prevention of mental health problems resulting from violence. The inclusion of promotion interventions was outside the scope of this report, but they are important to consider as a complement to more targeted psychosocial interventions.

Interventions Summary

This section provided examples of interventions with strong or promising evidence to address children's mental health and psychosocial well-being, especially interventions with demonstrated evidence in low-income and/or conflict-affected settings. To the authors' knowledge, no child-focused psychosocial program has obtained long-term follow-up data on the prevention of future perpetration or experiencing of IPV. However, **these programs have significant potential to address the psychological consequences of exposure to violence for children, and although more evidence is needed, to break the intergenerational transmission of violence.** This section highlighted interventions across four levels: individual/group-based, family-based, school-based, and community-based. Each of these areas has unique advantages and disadvantages. For example, although targeted individual and group-based interventions have a large evidence base on improving child and adolescent mental health and well-being, these interventions do not sufficiently address the full environment of a child's life. On the other hand, school- or community-based interventions may promote a healthy environment for all children, but there will be those who may fall between the cracks and need more targeted/intensive interventions. Best practices in psychosocial programming consider a scaffolding approach in which all young people receive minimal intervention and are supported by safe and nurturing environments – as are the adults in their lives – and in which more targeted and intensive interventions are available for children with greater needs.

PART THREE

KEY FINDINGS AND RECOMMENDATIONS

Key Findings and Recommendations

This third and final section reflects on lessons learned in the development of psychosocial interventions as a means to prevent the intergenerational transmission of violence. It also strives to highlight potential future innovations in programming aiming to break the cycle of violence between childhood exposure to violence and maltreatment and the risk for future perpetration. The section also presents areas of caution: important aspects related to avoiding stigma or undermining other important areas of violence prevention programming.

Interventions With the Most Evidence

This report set out to summarize psychosocial interventions with the most evidence of benefit for children exposed to violence. The majority of research in this area focuses on clinical or family interventions. Although school and community interventions are important, it should be noted that less research exists on these types of broader interventions or approaches (including, for example, indigenous approaches). **The most-studied intervention for children with a history of exposure to violence is CBT with a trauma focus**, which is presented as the most appropriate treatment for PTSD and considered an effective treatment for children with mild depression and generalized anxiety (McMullen et al., 2013). CBT with a trauma focus has been effectively delivered in a variety of settings, including in the Global South and in schools. Still, CBT with a trauma focus has limitations: It can be costly and often requires highly skilled implementers, and it may lack effectiveness with children exposed to multiple or ongoing traumas. Furthermore, CBT with a trauma focus and most other effective treatments involve parents or caregivers in some way. However, a need exists to better define the most advantageous role for parental involvement, especially for parents who are themselves at risk of using violence (Leenarts et al., 2013). For example, the potential exists for additional harms to a child when a caregiver who uses violence is involved in the therapy. For situations in which a non-offending caregiver is not available, an approach involving both a child and caregiver is likely inappropriate.

Other psychotherapeutic interventions could also be important for use with children or adolescents in terms of breaking the cycle of violence. **IPT-A has a broad evidence base and is also highly adaptable across cultures** given the relationship-focused nature of the intervention and its potential

for delivery by non-specialists. **Transdiagnostic interventions (those with the potential to address several co-occurring mental health conditions such as PTSD, depression, or conduct disorder) are particularly relevant for use with children and adolescents exposed to violence.** On a related note, family-based interventions, especially those that contain substance abuse programming for adults, may also prove useful. Yoga and mindfulness interventions, albeit having less evidence of impact with young people, may also prove to be effective interventions or components of other programs. School-based programming is more complex and some approaches, such as CBI, have mixed evidence. However, given their reach to children and their families, schools could be an important delivery site for programming; more schools are also realizing the need to address trauma among children to ensure their ability to reach educational goals. Fewer evidence-based community-level interventions exist that target the positive mental health of all children. While these interventions have promise to help promote a culture that appreciates mental health and reduces stigma, they are likely not enough (without also including more targeted group- or individual-level interventions) to reach children who have existing mental health difficulties. In these instances, school- and community-based programming might consider setting up referral services or forming relationships with mental health professionals to whom they could refer youth who need additional professional health services and support.

Adapting to Culture, Using Lay Facilitators, and Addressing Mental Health Stigma

The field of global mental health broadly, and the field of violence prevention specifically, are grappling with the issue of scaling up effective interventions.

The epidemic proportion of childhood exposure to violence and its severe consequences raise legitimate questions about the feasibility of bringing the types of psychosocial interventions presented in this report to the scale necessary to have widespread impact on improving mental health and preventing the intergenerational transmission of violence. The field of global mental health broadly, and the field of violence prevention specifically, are grappling with the issue of scaling up effective interventions. Significant limitations include the lack of funding for mental health and for violence prevention and response, as well as the need to increase the proportion of government health budgets that address these issues. There is also a severe lack of services and trained professionals, especially in the poorest countries and those affected by conflict and displacement. For example, the World Health Organization (2011) estimates the Democratic Republic of the Congo has only 0.015 trained psychologists in the mental health and education sector for every 100,000 people, equivalent to around one professional per 6 million individuals.

Another challenge, related to lack of funding, is an issue of the expertise and availability of mental health professionals. However, some of the studies presented in this report use non-mental health professionals in the facilitation of interventions. In addition, contrary to the common stereotype of psychotherapy as a treatment that has a long duration, the interventions included in this review were not overly intensive or long-term but rather typically demonstrated efficacy in a period of eight to 12 weeks of weekly sessions. Finally, many of these interventions demonstrated efficacy in a group-delivery mode, which is both more appropriate for many collectivist cultures and more efficient for scaling up.

Findings from several studies revealed the feasibility of implementing psychosocial interventions across culturally diverse and low-resource settings.

Findings from several studies revealed the feasibility of implementing psychosocial interventions across culturally diverse and low-resource settings. Although certain interventions, such as CBT with a trauma focus and IPT, were developed for Western participants, their ability to be culturally adapted and feasibly implemented in other settings is a key finding. For example, Ertl and colleagues (2011) highlight that the main strength of their study using CBT with a trauma focus in northern Uganda is that it was designed to reflect real-world programming, such as including lay personnel from the local communities to serve as therapists (after receiving training) and to deliver programming within the community. Other programs, such as Living Peace (which is for adults), can also be delivered in the community by non-mental health professionals.

In addition, studies indicate that schools offer an important venue for the provision of psychosocial services to children. There is evidence from multiple studies that a better ratio of students to school-based mental health professionals can reduce school-based violence and other disciplinary problems, indicating that schools are an important resource in providing services at scale (Fazel et. al, 2014; Lapan, 2012).

Stigma around mental health and psychosocial well-being exists in nearly every cultural context. Part of effective delivery of any intervention must consider how to overcome this stigma. In many parts of the world, mental health is poorly understood and viewed only as an issue pertaining to people who are "mad," "crazy," or even "possessed." Severe human rights abuses occur against some people with mental health conditions. Successful interventions should consider how to include mental health stigma reduction, literacy, and psychoeducation for communities at large in order to increase the acceptability of interventions and improve long-term sustainability. One aspect of this work involves carefully considering and testing the language of program delivery to use non-stigmatizing words and approaches. This report provides numerous examples of evidence-based interventions that have been adapted to new contexts while maintaining fidelity and effectiveness.

Avoiding Survivor Blame and the Stigma Trap

In presenting the evidence on how psychosocial interventions may prevent the intergenerational transmission of violence, **programs must take care to avoid further stigmatizing or blaming individuals or families.** While many of the risk factors for intergenerational violence and mental health conditions described here are supported by evidence, it must be emphasized – especially in any kind of intervention – that exposure to violence does not automatically lead to mental health conditions or involvement in violence later in life. First, not all men exposed to violence in childhood grow up to be perpetrators of gender-based violence. Indeed, men's critical reflection on experiences of vulnerability, fear, and oppression from violence in childhood can help to prevent their perpetration of violence against women. Equally important to note is that not all women who experienced violence in childhood will experience violence in adulthood, and in no way should their history of experiencing violence or subsequent mental health challenges be used to blame women for violence used against them in adulthood.

In addition, mental health conditions should never be seen as a cause of violence. To make such a claim runs a great risk of stigmatizing people with mental health conditions as being people to fear or pity. To make such assumptions on the singular importance of mental health in preventing violence also ignores a critical feminist analysis of the patriarchal roots of violence and gender inequality. Other risks related to stigma include individuals being identified as "deficient" as a result of their participation in psychosocial interventions. Studies reviewed for this report cite approaches taken to avoid stigmatizing program participants. For example, by choosing to create a heterogeneous group of child soldiers and other children affected by war, McMullen and colleagues (2013) were better able to avoid stigmatization of former child combatants. Similarly, to minimize the stigma associated with experiencing sexual abuse and rape, another study used a more inclusive eligibility criterion of either witnessing or experiencing sexual violence (O'Callaghan et al., 2013). Other useful approaches may include using positive, non-stigmatizing names for interventions or groups.

Gendered Approach to Interventions

A relevant consideration for psychosocial interventions is whether there are differential effects for girls and boys receiving these interventions. Several studies noted a difference in effects between girls and boys.[11] In part, biological differences in PTSD and other mental health conditions may play a part in impacting these differences. Leenarts and colleagues (2013) posited that despite known gender differences in the development of PTSD and co-occurring symptoms, with higher rates among girls and women, further attention should be paid to treatment responsiveness. For example, the majority of participants in CBT with a trauma focus studies have been girls, and more research is needed on the potentially gendered nature of many

[11] A recent systematic review and individual participant data meta-analysis on focused psychosocial interventions for children in low-resource humanitarian settings found that interventions were equally effective for boys and for girls (Purgato et al., 2018). However, more research is needed to understand if this lack of gender effect stands across non-humanitarian settings and/or for other outcomes. Further, gendered differences in implementation factors (e.g., attendance, participation, or fidelity) should also be considered.

of the key intervention components. For example, in most cultures, boys are less likely than girls to be socialized to develop emotional expression or be encouraged to develop self-reflection on the connection between feelings and behaviors; boys are also less likely to seek professional help or informal support. Different life experiences and expectations for boys versus girls may also impact differences in program outcomes. Some studies found greater effectiveness for girls and asked, for example, whether creating an empathic environment and sharing traumatic experiences may be easier among girls than boys, thus facilitating the healing process. In studies for which treatment effects were seen for boys and not girls, different questions may arise, such as on girls' ability to attend sessions or the programs' ability to meet the specific needs of girls.

Future Directions for Research and Programming

As mentioned earlier, the purpose of this report is not to suggest that psychosocial interventions, in and of themselves, will prevent the intergenerational transmission of violence but rather that they may be a key missing component of comprehensive violence prevention and response programming. Primary prevention of both gender-based violence and violence against children that addresses the causes of violence rooted in gender inequality and social norms is critical to preventing violence and, subsequently, to preventing a wide range of other negative consequences from violence (including mental health conditions). The intention of this report is to highlight the ways in which social norms and gender justice approaches to primary prevention can be bolstered by interventions that also contain a specific focus on mental well-being and address the intergenerational transmission of violence. Supporting programs that improve mental health may not only have the benefit of preventing violence in the long run but also have the significant value of improving the immediate lives of survivors of violence.

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To date, psychosocial programming for children has little to no evidence of widespread scale-up. Although a dearth of trained mental health professionals (especially for children and adolescents) exists in nearly all countries, child protection/welfare systems may be a potential place to implement and scale these approaches. Other sectors should also consider how to engage in psychosocial programming or promotion, such as health, education, or faith communities. Of course, scaling up requires important considerations, including adequate training, supervision, and support (emotional, financial, physical, and otherwise) for service providers. Partnerships with local mental health institutes or universities could be leveraged to improve psychosocial approaches for service providers across sectors.

This report focuses on interventions specifically for children or adolescent survivors of violence. **However, a range of psychosocial programming also exists for adults with a history of childhood trauma.** For example, as mentioned earlier, the Living Peace intervention in the Democratic Republic of the Congo focuses on group psychoeducational interventions for men exposed to conflict-related violence and often childhood trauma. A qualitative evaluation of the program after three years of implementation revealed sustained behavioral change that led to the reduction of IPV (Tankink & Slegh, 2017). Among the important contributors to men's reduction of IPV against their partners were a reduction or moderation in alcohol use and having no serious mental health problems, and similar impacts were also found among the broader community connected to the intervention (Tankink & Slegh, 2017). Other important interventions with adults may include interventions related to reducing harmful alcohol use among men or depression treatment for women. **Exploring ways to adapt such psychosocial programming with adults that have a history of childhood trauma to include components working with children and adolescents could yield important outcomes.**

Although most of the interventions referenced in this report provide rigorous intervention and follow-up designs, the authors were not able to identify interventions that evaluated long-term reductions in violence perpetration or experiences. **Future research should include long-term follow-up on violence outcomes as a result of psychosocial interventions.** Furthermore, most of the programs evaluated were not implemented at more than one time for a population of violence-exposed and maltreated children and adolescents. However, the authors recognize that the cost of implementing interventions is high and that research design and follow-up are labor- and time-intensive. The authors believe that an important consideration for the programming of interventions aiming to break the cycle of violence is to include programming across the life cycle. Other areas of future research that may inform programming are on the potential factors that may interrupt the cycle of violence: for example, why some children demonstrate more resilience to avoiding future violence. **While further advancing the research base is critical, it is also important to act on the existing evidence on the benefits of psychosocial interventions.**

Adolescence is a critical time in which victimization and perpetration of violence may co-occur or in which people may transition swiftly between childhood exposure to violence and violence in intimate relationships. The authors found evidence of studies addressing outcomes of exposure to violence and maltreatment (e.g., PTSD, depression, and anxiety symptoms), as well as outcomes on externalizing and aggressive behaviors. Most psychological problems (including those linked to future violence/IPV) have their onset in adolescence or early adolescence, making this developmental period even more critical to address (Whiteford, Degenhardt, Rehm, Baxter, & Ferrari, 2013). However, this review did not find studies that include mental health interventions with programming to prevent future perpetration

among adolescents exposed to violence and maltreatment; findings do show, though, that approaches such as Youth Living Peace and Expect Respect have promising potential. In many contexts around the world, children and adolescents transition into adulthood and become parents at young ages. For children exposed to violence and maltreatment, the time between when trauma(s) are experienced and the transition into adulthood may be very short. Given this short transition period, early and late adolescence are critical for psychosocial and preventive (both primary and secondary) interventions to take place.

Future Directions for Policy and Funding

Given the evidence presented here on the links between childhood exposure and adult perpetration of IPV, and on the promising potential of current interventions, governments and donors should invest in further building the evidence base and taking existing responses to scale within policies and systems. This includes national policy commitments to address the psychosocial impact of children's exposure to violence, as well as integrating such approaches into the education and health systems, among others, at all levels, and significantly improving training to build a cadre of local mental health professionals. Funding is also needed for broader-level approaches focused on creating supportive, trauma-informed spaces to protect and nurture the developing brains of young people.

Governments and donors should invest in further building the evidence base and taking existing responses to scale within policies and systems.

Conclusion

This report highlights the potential role that mental health and psychosocial interventions for children and adolescents, as part of a comprehensive violence prevention and response strategy, can play in meeting their current needs, in helping them live happier, more productive, healthier lives, and in preventing future violence against women. While more evidence, experimentation, and collaboration are needed on psychosocial programming as a complement to other prevention approaches, initial evidence suggests there is a potential and important opportunity to advance future violence prevention programming. Although witnessing or experiencing violence in childhood is not the *only* driver of men's perpetration of IPV and women's experiencing IPV, it is consistently a factor found in research on survivors and perpetrators. Given the rates of childhood witnessing of violence, and the rate of IPV globally, comprehensive prevention and response to IPV in virtually any setting should include culturally appropriate, gender-transformative, and evidence-based psychosocial interventions as part of a comprehensive local prevention and response package. This entails engaging appropriate partners in each country/setting, including systemic interventions, and ensuring any programming is scaleable and sustainable.

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