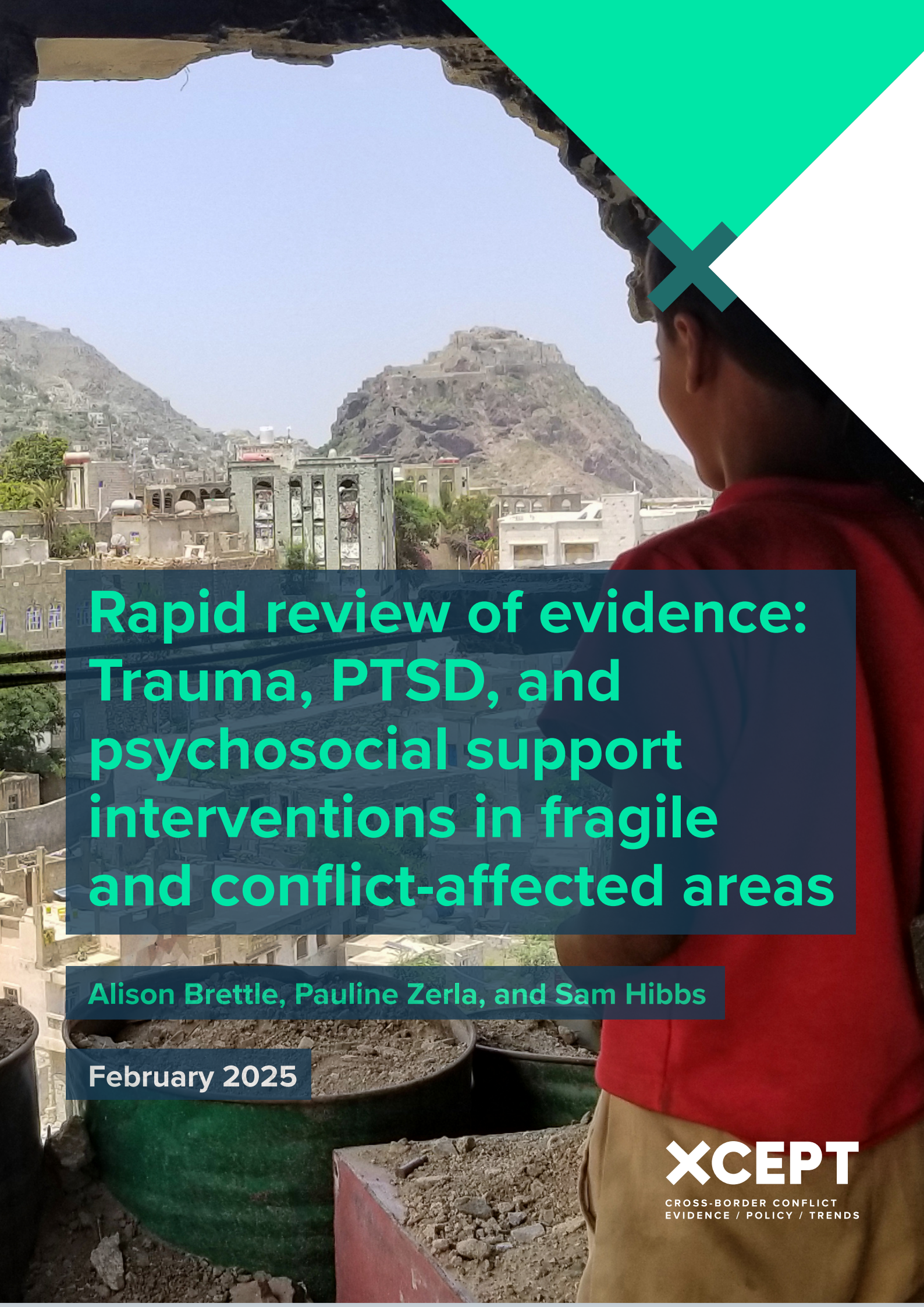

# Rapid review of evidence: Trauma, PTSD, and psychosocial support interventions in fragile and conflict-affected areas

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## About XCEPT

This publication is a product of the Cross-Border Conflict Evidence, Policy and Trends (XCEPT) research programme, funded by UK International Development. XCEPT brings together world-leading experts and local researchers to examine conflict[1] affected borderlands, how conflicts connect across borders, and the drivers of violent and peaceful behaviour, to inform policies and programmes that support peace. For more information, visit **www.xcept-research.org** or contact us at **info@xcept-research.org.**

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# Contents

# Executive summary

## Aims

The aim of this review of evidence (RoE) is to identify what types of interventions are most effective in mitigating the negative effects of conflict-related trauma amongst civilian and combatant populations in fragile and conflict-affected areas. Its purpose is to help inform the Cross-border Conflict Evidence, Policy and Trends (XCEPT) research by King's College London on trauma, mental health, and violent and peaceful behaviours, as well as wider policy and programming debates concerning trauma-related interventions and approaches.

## Background

The greatest challenge for policymakers and practitioners in any transition out of war is to build peace and trust in communities that have experienced prolonged or repeated violence, and to transform harmful relationships, attitudes, and behaviours forged during conflict, thus reducing the risk of a return to violence. There is increasing recognition that collective and individual trauma can undermine these efforts if it is not identified and addressed.

Collective trauma can be a contributing factor to the root causes of protracted social conflict – the kind of cyclical, endemic violence currently witnessed in fragile and conflict-affected states (FCAS) such as Iraq, South Sudan, and Syria. In such situations, social systems and networks (fundamental to peacebuilding and social cohesion) often disintegrate or become fragmented. Failure to assuage communal trauma limits the likelihood that social cohesion will develop; it also limits the effectiveness of wider peacebuilding interventions. Whilst there are many different interventions designed to tackle trauma, there is little consensus amongst practitioners, policymakers, and academics regarding what works and why. As such, it is critically important to gain a better understanding of the common elements in interventions that help reduce the negative effects of conflict-related trauma.

## Methods

This review examines 95 studies (including academic articles, policy reports, programme evaluations, and grey literature) published in English between 2000 and 2020. A systematic search generated 6,831 articles, 73 of which met the inclusion criteria. A hand search generated another 64 articles, 22 of which were included.

## Key findings

The evidence base of what helps individuals and groups recover from trauma in FCAS is fragmented. The review finds that the following interventions can be effective in mitigating the negative effects of trauma: cognitive processing therapy (CPT), cognitive behavioural therapy (CBT), narrative exposure therapy (NET), and teaching recovery techniques (TRT). In terms of training, integrating external programmatic approaches with local approaches is critical.

The review also identified some elements that are common to the most effective interventions:

- Interventions reduce trauma symptoms more effectively when they (a) provide individuals with access to alternative forms of support beyond their immediate family/friendship group, or (b) strengthen existing relationships (e.g. between partners or between children and parents).
- Creating opportunities for people to socialise, be listened to, and share experiences and advice is important.
- Local, community-based mental health workers can deliver mental health interventions effectively, but only if they are given the latitude to adapt Western models and treatments to the needs of their communities.
- Sustained engagement and involvement of the local community is critical.
- Livelihood provision and support are important, but not sufficient on their own, to ameliorate trauma symptoms at the individual level, but they are more effective at the community level.

- Some individuals who commit violence in the aftermath of violent conflict may have developed an 'appetite for aggression' which 'protects' them against trauma. Such individuals may benefit from violence/aggression reduction interventions rather than trauma-focused ones.

- Labelling interventions as 'trauma-focused' can exacerbate individual and communal stigma for those enrolled.

## Limitations and gaps

The review identified significant limitations in the existing evidence base. Nuanced cultural adaptation and recognition of the heterogeneity of actors, approaches, and relationships that shape the causes and solutions to trauma in FCAS are limited. Studies mainly focused on civilian populations, women and children, and child soldiers. Adult male perpetrators of violence, such as fighters, were largely excluded from interventions. Western frameworks, norms, knowledge, and practice dominate the field. There is no robust evidence base for more community-based, culturally relevant interventions.

Programmes tend to focus on providing individual rather than group/community level interventions, yet how individual treatments can benefit wider social groups or communities is under-analysed. Few of the studies explicitly explored the effects of the intervention strategies on violent and/or peaceful behaviour, and only a handful examined them from a social cohesion or social support perspective. Finally, there is a lack of evidence on the sequencing of interventions to reduce trauma.

## Key recommendations

- **Programming should provide opportunities for people to strengthen existing relationships** and develop new ones, enabling them to recognise and manage their own and others' trauma-induced behaviours.

- **Programmes and policies should be expanded to include traumatised populations** who may have perpetrated violence rather than focusing only on the victims of violence.

- **The timing of interventions to mitigate the negative effects of trauma is critical**. Interventions should be sequenced starting with 'lighter', low-impact interventions that create opportunities for people to meet and talk.

- **In terms of sustainability and effectiveness, policies need to identify and amplify local practices, actors, and institutions** that already exist or are being utilised by communities to deal with the impact of trauma, even if these activities and practices are not labelled or understood by the local community as being 'trauma-focused'.

# List of abbreviations

| | |
|---|---|
| ACE | Adverse childhood experiences |
| BATD | Behavioural activation treatment for depression |
| CBT | Cognitive behavioural therapy |
| CETA | Common elements treatment approach |
| CHW | Community health worker |
| CPT | Cognitive processing therapy |
| GBV | Gender-based violence |
| IDP | Internally displaced persons |
| IPV | Intimate partner violence |
| MHPSS | Mental health and psychosocial support |
| NET | Narrative exposure treatment |
| PSS | Psychosocial support |
| PTSD | Post-traumatic stress disorder |
| RCT | Randomised controlled trial |
| TRT | Teaching recovery techniques |
| TF-CBT | Trauma-focused CBT |

# Introduction

One of the most significant obstacles in transitioning out of war is to build peace and trust in communities that have experienced prolonged or recurring violence, and to reshape the harmful relationships, attitudes, and behaviours forged during conflict to reduce the risk of a return to violence. There is a growing body of literature that addresses how collective and individual trauma can undermine these efforts if not identified or addressed. This rapid review of evidence (RoE) identifies which interventions have been most effective in helping conflict-affected populations in the Middle East and North Africa (MENA) and Sub-Saharan Africa (SSA) recover from psychological trauma stemming from exposure to violence.

One aim of the RoE is to inform research conducted by King's College London (KCL) under the Cross-border Conflict Evidence, Policy and Trends (XCEPT) programme, which seeks to explore the factors that influence violent and peaceful behaviour in conflict contexts, and identify ways to sustainably reduce violence, support conflict recovery, and enable peace and reconciliation. Research by XCEPT explores how and why people return to cohesive and peaceful functioning after experiencing violence and focuses on those individuals and communities most traumatised by conflict. This group is at greatest risk of returning to violence.[1] Collective trauma is believed to be a key cause of protracted violent conflict[2] – the kind of cyclical, endemic violence currently witnessed in Syria, South Sudan, and Iraq, where XCEPT KCL research focuses. In protracted conflicts, social systems and networks (fundamental to peacebuilding and social cohesion) have often disintegrated or fragmented. Trauma limits the likelihood that social cohesion will take shape and limits programme effectiveness.[3] For example, it may be difficult to implement interventions focused on building social cohesion or training, if social and interpersonal issues have not been addressed.

XCEPT KCL research focuses on deepening insight into both violent and peaceful behaviour and the interventions that support recovery from post-conflict trauma – a crucial complement to the security, political, and economic tools of stabilisation and peacebuilding. Based on analysis of studies identified in this review, the RoE highlights several empirical and conceptual gaps and limitations that XCEPT KCL can address through its research themes and longitudinal, nested mixed-methods research design. In addition, based on the existing evidence, the paper suggests a number of policy implications and programme recommendations. The paper has three core objectives:

1. To identify what types of interventions are most likely to be effective in mitigating the negative outcomes of trauma amongst civilian and ex-combatant populations exposed to violent conflict in Syria, South Sudan, and Iraq, and why.

2. To identify 'common elements' and what works to reduce trauma across different groups and countries in MENA and SSA.

3. To identify gaps in the existing evidence (empirical and theoretical) that XCEPT KCL research can fill conceptually and programmatically.

The review is structured as follows. Section 1 describes the methodology and overview of study characteristics. Section 2 identifies what works and what does not work for each intervention theme. Section 3 discusses the limitations and evidence gaps, and Section 4 summarises the key findings and provides some recommendations.

1 T. Barker, S. Maher and C. Larkin, "Conflict Trauma and Violence: How Can We Promote Peace?", ICSR, 9 March 2022, https://icsr.info/2022/03/09/conflict-trauma-and-violence-how-can-we-promote-peace/#:~:text=The%20documented%20link%20between%20trauma,form%20of%20recurrent%20trauma4.

2 See, for example, J. Rinker and J. Lawler, "Trauma as a Collective Disease and Root Cause of Protracted Social Conflict", *Peace and Conflict: Journal of Peace Psychology* 24, no. 2 (2018): 150–64.

3 J. Lewis and S. Topal, "Proximate Exposure to Conflict and the Spatiotemporal Correlates of Social Trust", *Political Psychology* 44, no. 3 (2022), 667–87.

# 1. Methodology

This section outlines the systematic search design and additional search inputs, and briefly discusses some of the challenges involved. Relevant literature – including journal articles, programme evaluations, and policy papers – published in English between 2000 and 2020 was (a) searched systematically, and (b) identified through a hand search. Key word searches, quality assessment procedures, and inclusion/exclusion criteria are described in detail in the Appendix.

The systematic search was conducted on the following databases: PsycINFO, Psychology and Behavioral Sciences Collection, PubMed, Cochrane Central Register of Controlled Trials, PILOTS, and Web of Science Core Collection.

The hand search of field resources and grey literature included reports from Médecins Sans Frontières (MSF), Psychological Centre for the International Federation of the Red Cross and Red Crescent Societies, Mental Health and Psychosocial Support Network (MHPSS), UNCHR, Devex, ReliefWeb, the World Bank, Save the Children, UNICEF, Mercy Corps, War Child, UN Children and Armed Conflict, Search For Common Ground (SFCG), International Alert, Conciliation Resources, Alliance for Peacebuilding, International Society for Traumatic Stress Studies (ISTSS), Saferworld, Human Rights Watch, and the Global Trauma Project.

The systematic search generated 6,831 English articles published between 2000 and 2020, 73 of which met the inclusion criteria: this included 19 systematic reviews. As this analysis offers a rapid review of the evidence, relevant systematic reviews were included. The hand search generated 64 articles, 22 of which met the inclusion criteria. This resulted in a total of 95 publications included for review. The 76 studies which looked at specific interventions were assessed according to six principles of research quality outlined in a 2014 'How To' note from the United Kingdom Department for International Development (DFID) and previous rapid reviews commissioned by DFID (see the Appendix for details and for inclusion/exclusion criteria).

Grey literature and field-based studies were included to help identify mechanisms that may work in the field but have not yet been subject to more rigorous testing and evaluation. This is important, given the theory-practice gap, particularly regarding children and adolescents.[4] However, few policy or field-based studies made it into the final selection, mostly because their methodology was not sufficiently rigorous to meet the inclusion criteria (see the Appendix), or because they were unavailable. Indeed, given their focus on providing immediate support and fulfilling basic needs in fragile and conflict-affected states (FCAS), most field-based organisations simply do not have the time or manpower to conduct evaluations of their trauma-focused interventions. IOM (2014), for example, suggests that most forms of psychosocial support for internally displaced persons (IDPs) in FCAS comprise 'counselling', but evaluations appear to be scarce.[5]

Book chapters and publications in languages other than English were excluded. This may mean that relevant evaluations and analyses were missed. However, 19 systematic reviews were used to supplement the findings presented here, adding to the breadth and depth of the papers analysed. Fourteen of these systematic reviews focused on children and youth, and one specifically on women and children;[6] one covered trauma interventions for victims of torture,[7] whilst others looked at adult refugees[8] and 'best practices'.[9]

4 T. Bosqui and B. Marshoud, "Mechanisms of Change for Interventions Aimed at Improving the Wellbeing, Mental Health and Resilience of Children and Adolescents Affected by War and Armed Conflict: A Systematic Review of Reviews", *Conflict and Health* 12, no. 15 (2018).

5 Middle East and North Africa International Organisation for Migration Annual Report, 2014; https://publications.iom.int/system/files/pdf/mena_annual_report_2014.pdf

6 M. Kamali et al., "Delivering Mental Health and Psychosocial Support Interventions to Women and Children in Conflict Settings: A Systematic Review", *BMJ Global Health*, 5, no. 3 (2020): e002014.

7 M. Bunn et al., "Group Treatment for Survivors of Torture and Severe Violence: A Literature Review", *Torture* 26, no. 1 (2015): 45–67.

8 A. Kip et al., "Psychological Interventions for Posttraumatic Stress Disorder and Depression in Refugees: A Meta-Analysis of Randomized Controlled Trials", *Clinical Psychology & Psychotherapy* 27, no. 4 (2020): 489–503.

9 D. Pedersen, H. Kienzler, and J. Guzder, "Searching for Best Practices: A Systematic Inquiry into the Nature of Psychosocial Interventions Aimed at Reducing the Mental Health Burden in Conflict and Post-Conflict Settings", *SAGE Open* 5 (2015).

The focus on women and children reflects wider developmental interests and UN policy. However, it does mean that other groups of people are often neglected in terms of trauma interventions and analysis (see below for a more detailed discussion on 'missing populations' in FCAS).

## 1.1 Descriptive statistics

### 1.1.1 Geographical distribution

Most studies (approximately 60%) were conducted in SSA and the remainder in MENA, in particular Iraq, Syria, and Turkey. The geographical distribution (see Figure 1) is unsurprising given the focus on trauma-based interventions emerging from civil wars and endemic conflict in the 1990s and early 2000s.

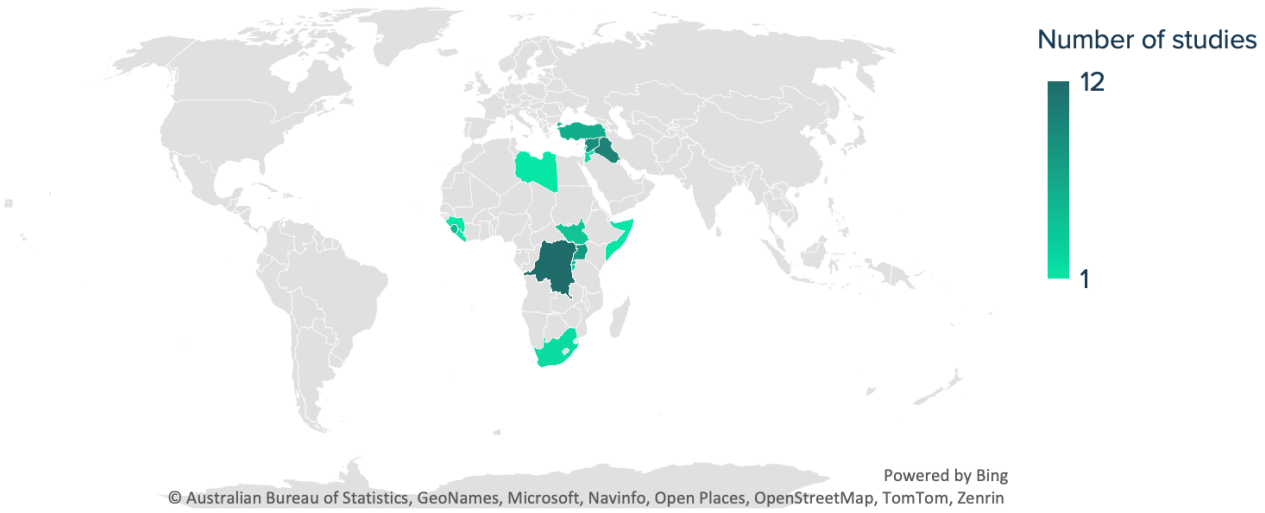
We identified only five studies conducted in South Sudan – a relevant fact given XCEPT KCL's geographical research focus on Syria, South Sudan, and Iraq. Most of them were qualitative or experimental; we were unable to identify any randomised controlled trials (RCTs) from South Sudan. There were several studies which explored psychological trauma and population needs in South Sudan,[10] but they were excluded from the review because they did not evaluate interventions. Further, we lack robust studies that account for multiple episodes of violence and trauma that South Sudanese populations may have experienced. Notably, three of the Ugandan studies included in this RoE focused on South Sudanese refugees.

### 1.1.2 Research methods

Articles were also categorised according to research method (see Figure 2). RCTs made up the largest proportion (35%) of studies, including clustered randomised controlled trials (cRCTs). A further 11 studies (14%) were experimental or quasi-experimental in design. The figure shows that approximately two-thirds (66%) of studies employed quantitative and statistical methods to analyse baseline characteristics and outcomes. Case studies made up less than 5% of all studies, and there were no comparative case studies. Eleven studies (14%) employed purely qualitative methods, including interviews and focus group discussions (FGDs), whilst just a few (12%) combined qualitative and quantitative methods. Of the three trials, only one was a clinical trial testing a psychopharmacological treatment.

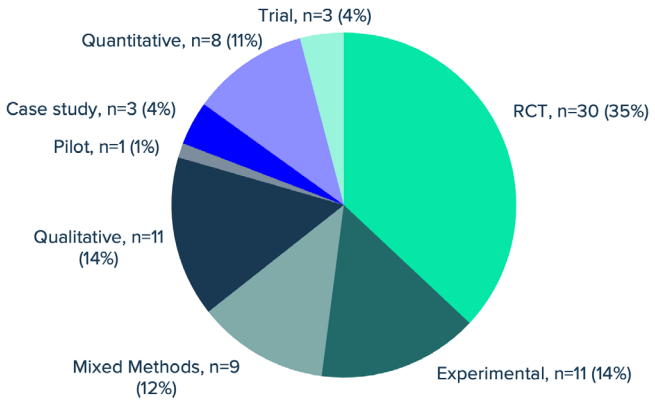
This figure below shows the geographical distribution of the 76 studies covered in this RoE. One multisite study is not included in this figure, which was conducted in Jordan, Palestine, Egypt, Lebanon, Iraq, Tunisia, Iraq, Libya, Sudan, Syria. Raw data can be found in the Appendix.

**Figure 1. Countries covered by studies in this RoE**




10 See, for example, T. Ayazi et al., "Association Between Exposure to Traumatic Events and Anxiety Disorders in a Post-Conflict Setting: A Cross-Sectional Community Study in South Sudan", *BMC Psychiatry* 14, no. 1 (2014): 1–10; and T. Ayazi et al., "Community Attitudes and Social Distance Towards the Mentally Ill in South Sudan: A Survey from a Post-Conflict Setting with No Mental Health Services", *Social Psychiatry and Psychiatric Epidemiology* 49, no. 5 (2014): 771–80.

### Figure 2. Types of studies covered in the RoE




### 1.1.3 Study design/methodology by country

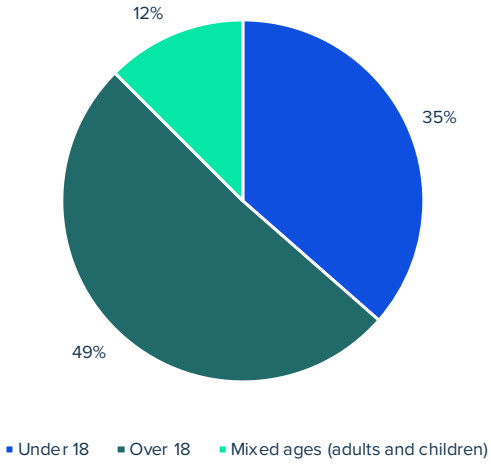
High-quality studies, particularly RCTs, tend to be clustered in certain geographical contexts and focus on certain conflict-affected populations. For example, most of the RCTs represented in this RoE were conducted in Iraq (4), the Democratic Republic of the Congo (DRC, 7), or Uganda (5). There were few RCTs conducted systematically across different contexts and populations.

For example, although there is robust evidence suggesting that a common elements treatment approach (CETA; see the Appendix for a glossary of interventions) reduced trauma symptoms in DRC (and to a lesser extent in Iraq) and in populations who have witnessed violence or been victims of violence, we do not yet know whether this also applies (a) to South Sudan and (b) to subjects who perpetrated the violence.

### 1.1.4 Participant characteristics

Figure 3 and Figure 4 show that the majority of studies were about adults of both sexes. A number of studies focused on war-affected populations identified by authors as particularly vulnerable, including orphans, victims of sexual violence, and torture. Only one study in Syria mentioned disabled participants,[11] and only one study specifically included widows.[12] This suggests that more needs to be done to include disabled and other minority groups in the delivery and assessment of interventions.

### Figure 3. Studies covered by this RoE by age group researched




Six studies focused on orphans: one in South Sudan,[13] one on orphaned former child soldiers in Sierra Leone,[14] and four in Rwanda.[15] Victims of torture were the focus of seven studies: one in South Africa,[16] one in a Guinean refugee camp for Sierra Leonean and Liberian refugees,[17] three in Iraq,[18] one on couples who had experienced torture in

11 D. Ziveri, S. Kiani, and M. Broquet, "The Impact of Psychosocial Support on Well-Being and Agency within an Inclusive Livelihood Programme", *Intervention* 17, no. 1 (2019): 86–95.

12 N. Jacob et al., "Dissemination of Psychotherapy for Trauma Spectrum Disorders in Postconflict Settings: A Randomized Controlled Trial in Rwanda", *Psychotherapy and Psychosomatics* 83, no. 6 (2014): 354–63.

13 B. Muller, B. Munslow, and T. O'Dempsey, "When Community Reintegration Is not the Best Option: Interethnic Violence and the Trauma of Parental Loss in South Sudan", *International Journal of Health Planning and Management* 32, no. 1 (2017): 91–109.

14 D. Harris, "Pathways to Embodied Empathy and Reconciliation after Atrocity: Former Boy Soldiers in a Dance/Movement Therapy Group in Sierra Leone", *Intervention* 5, no. 3 (2007): 203–31.

15 S. Schaal, T. Elbert, and F. Neuner, "Narrative Exposure Therapy Versus Interpersonal Psychotherapy", Psychotherapy and Psychosomatics 78, no. 5 (2009): 298–306.; S. Nayak, S. Kshtriya, and R. Neugebauer, "Trauma Alleviation Treatment for Unaccompanied Children after the Rwandan Genocide: A Cautionary Tale", Intervention 17, no. 1 (2019): 23–30; P. d'Ardenne and M. Kiyendeye, "An Initial Exploration of the Therapeutic Impact of Music on Genocide Orphans in Rwanda", *British Journal of Guidance & Counselling* 43, no. 5 (2015): 559–69; Jacob et al., "Dissemination of Psychotherapy".

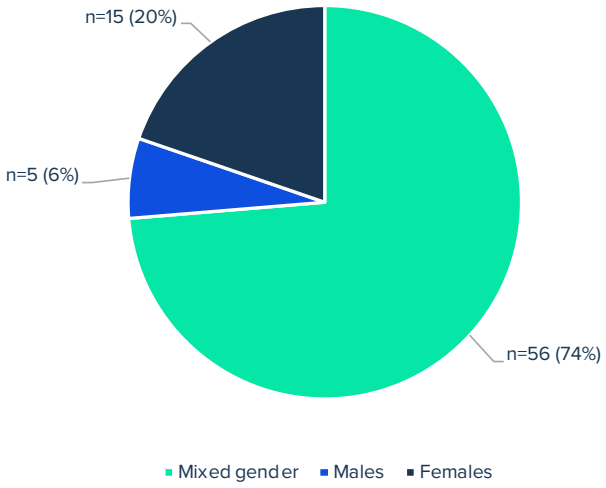
16 D. Dix-Peek and M. Werbeloff, "Evaluation of the Efficacy of a South African Psychosocial Model for the Rehabilitation of Torture Survivors", *Torture* 28, no. 1 (2018): 34–57.

17 S. Stepakoff et al., "Trauma Healing in Refugee Camps in Guinea: A Psychosocial Program for Liberian and Sierra Leonean Survivors of Torture and War", *American Psychologist* 61, no. 8 (2006): 921–32.

18 Z. Mahmooth et al., "Study Participant Reported Outcomes of Mental Health Interventions: Results from a Randomized Controlled Trial among Survivors of Systematic Violence in Southern Iraq", *Global Mental Health* 5 (2018): e19; J. Bass et al., "A Randomized Controlled Trial of a Trauma-Informed Support, Skills, and Psychoeducation Intervention for Survivors of Torture and Related Trauma in Kurdistan, Northern Iraq", *Global Health, Science and Practice* 4, no. 3 (2016), 452–66.; W. Weiss et al., "Community-Based Mental Health Treatments for Survivors of Torture and Militant Attacks in Southern Iraq: A Randomized Control Trial", *BMC Psychiatry* 15 (2015): 249.

DRC,[19] and one assessing the impact of narrative exposure therapy (NET) in multiple MENA countries.[20]

**Figure 4. Studies covered, by gender focus**




## 1.2 Outcome measurements

A range of psychosocial outcomes were measured across RCTs, and results varied substantially. The most commonly assessed outcome domains were clinical measures such as post-traumatic stress, internalising symptoms (such as depression and anxiety), externalising symptoms (such as anger), and functioning. Other outcomes were also analysed, including pro-social behaviour, economic support, social capital, peer support, community acceptance/integration, stigma, and aggression.

Despite the relative diversity of outcomes mentioned across the papers, most studies focused on clinical mental health outcomes. Unsurprisingly, this was particularly the case with trauma-focused interventions. Where impact was measured, more often than not, it was defined narrowly and clinically rather than socially and relationally. Only a quarter of all trauma-focused studies acknowledged the wider effects of the interventions. For example, Gormez et al. looked at the assessed impact that group cognitive behavioural therapy (CBT) had on peer relationships,[21] whilst Betancourt et al. measured the reported clinical, social, and educational impact of a youth-centred group CBT in Sierra Leone.[22] Hall et al. evaluated the effect of a CBT intervention on social capital in DRC and found that it was reported to have increased group membership and participation.[23] Mogga likewise found that participation in CBT for gender-based violence (GBV) was reported to have improved women's perception of both their social support and their physical health.[24] This is one of the few papers that addressed physical health outcomes beyond those traditionally explored with clinical post-traumatic stress disorder (PTSD) measures, and is helpful in acknowledging the links between trauma and various physical health outcomes.[25]

Whilst Viller Hansen et al.[26] and Weiss et al.[27] are attentive to mental health outcomes of trauma interventions, they also report improvements in physical health and disability, and a reduction in stigma, respectively. Bass et al. investigated the combined impact of cognitive processing therapy (CPT) followed by a socio-economic programme on specific domains of individual, social, physical, and economic functioning in DRC.[28] They found that CPT was more effective in improving function and reducing symptoms of distress. Finally, Robjant et al. address the clinical, social and behavioural effects of narrative exposure therapy

19 E. Morgan et al., "The Development and Implementation of a Multi-Couple Therapy Model with Torture Survivors in the Democratic Republic of the Congo", *Journal of Marital and Family Therapy* 44 (2018): 235–47.

20 A. Viller Hansen et al., "Impact of NET on Torture Survivors in the MENA Region", *Torture* 27, no. 3 (2017): 49–63.

21 V. Gormez et al., "Evaluation of a School-Based, Teacher-Delivered Psychological Intervention Group Program for Trauma-Affected Syrian Refugee Children in Istanbul, Turkey", *Psychiatry and Clinical Psychopharmacology* 27, no. 2 (2017): 125–31.

22 T. Betancourt et al., "A Behavioral Intervention for War-Affected Youth in Sierra Leone: A Randomized Controlled Trial", *Journal of the American Academy of Child and Adolescent Psychiatry* 53, no. 12 (2014): 1288–97.

23 B. Hall et al., "The Effect of Cognitive Therapy on Structural Social Capital: Results from a Randomized Controlled Trial among Sexual Violence Survivors in the Democratic Republic of the Congo", *American Journal of Public Health* 104, no. 9 (2014): 1680–86.

24 R. Mogga, "Addressing Gender-Based Violence and Psychosocial Support among South Sudanese Refugee Settlements in Northern Uganda", *Intervention* 15, no. 1 (2017): 9–16.

25 We thank one of our anonymous reviewers for suggesting this.

26 Viller Hansen et al., "Impact of NET on Torture Survivors".

27 Weiss et al., "Community-Based Mental Health Treatments".

28 J. Bass et al., *Addressing Sexual Violence Related Trauma in Eastern DRC with Cognitive Processing Therapy*. World Bank, 2013.

for forensic offender rehabilitation (FORNET) on female ex-child soldiers, again in DRC.[29] Their study is particularly relevant to XCEPT KCL research because it is one of only a few that explicitly explore trauma and (violent) behaviour – a gap that XCEPT KCL research seeks to address. The study found that FORNET effectively reduces mental health problems as well as ongoing acts of violence in female former child soldiers. Significantly, the authors argue that there is a critical need for interventions to reduce violent behaviour and enhance pro-social behaviour, inclusion, and cohesion.

Overall, trauma-focused interventions are skewed towards a narrow understanding and categorisation of programme outcomes. Alternative and culturally embedded interventions consider more holistic, socially informed measurements such as 'community reintegration', 'social support', and 'reconciliation', yet these lack analytical precision and require more specific measurements concerning relational support, resources, and perceptions at the individual, group, and community levels to usefully inform programmes and policy.

This means that we do not know the multiple domains in which a specific trauma intervention can have an effect at the individual or group level. It is possible that trauma interventions that did not reduce PTSD may yet improve people's perceptions of peer support and peer acceptance. Therefore, despite efforts to evaluate programmes, it may be the case that evaluators are using the wrong sources of data to measure effectiveness. Similarly, 'non-trauma-specific' interventions, such as transitional justice mechanisms, local dispute resolution/mediation, or even radio programmes, may also have a positive (if unknown) impact on reducing trauma at the community level. As a policy community, we currently lack an interdisciplinary, holistic frame through which interventions can be measured holistically and analysed across populations and conflict-affected contexts. The interdisciplinary nature of XCEPT KCL's research means that we can measure and evaluate interventions in a more nuanced manner. Our longitudinal research design incorporates surveys that capture changes in behaviours, attitudes, and relationships as well as mental health. This will allow policymakers to better understand how and why a given intervention may shape perceptions, cohesion, and norms at both individual and group levels.

### 1.2.1 Intervention themes

Thirty intervention types were identified in the studies reviewed here (see Table 1). They represent a broad typology of strategies covering everything from mind-body interventions to CBT/CPT. Despite the relatively nascent field of trauma interventions,[30] a myriad interventions have been developed and implemented to tackle the negative impacts of conflict-related trauma. Indeed, there appears to be little consensus amongst policymakers, practitioners, and academics concerning what works. This is unsurprising given the complex nature of trauma and the different contexts and communities impacted by it. However, based on our analysis, and in order to simplify the somewhat disparate literature, this review groups interventions into five categories: (1) trauma-focused; (2) training of community health workers, caregivers, and counsellors; (3) psychosocial; (4) alternative and culturally informed; and (5) community-based.

As Figure 6 shows, some of these themes overlap. We are also cognisant that this typology is not reflected in the standard mental health and psychosocial support (MHPSS) literature. However, in order to synthesise broader findings for a non-specialist audience, we find that these themes are broadly reflective of two key debates within the field of trauma: (1) the tension between a narrower/clinical conceptualisation and practice of trauma-focused interventions and a broader/developmental understanding of interventions, with preference for community-centred ones; and (2) the prevailing preference for Western models of healing over culturally/locally embedded models (also termed 'traditional'), which is often due to

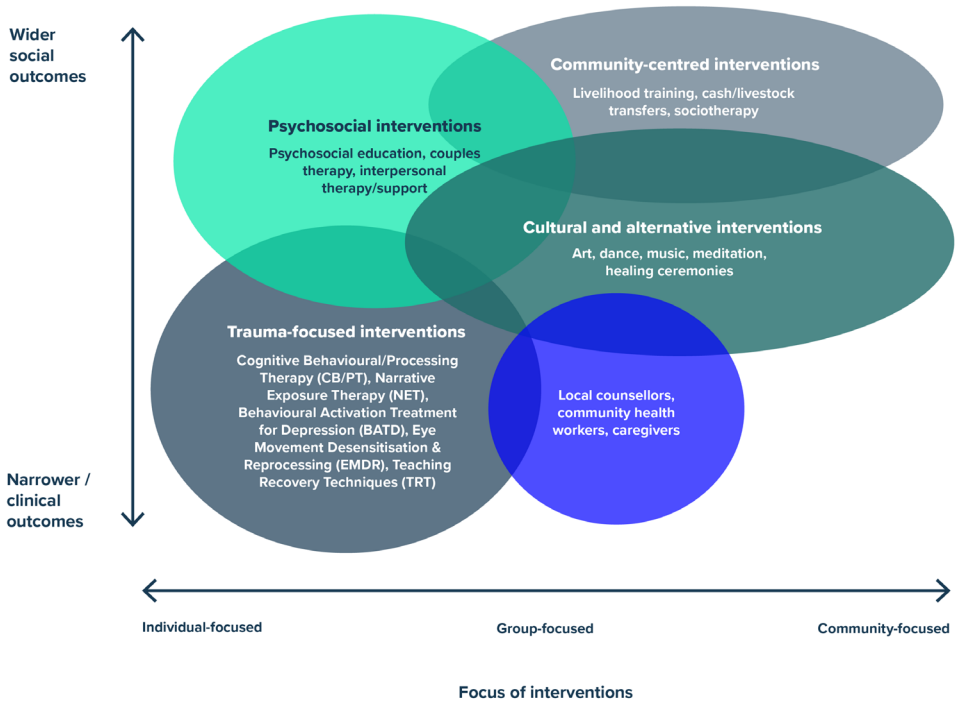
29 K. Robjant et al., "The Treatment of Posttraumatic Stress Symptoms and Aggression in Female Former Child Soldiers Using Adapted Narrative Exposure Therapy: A RCT in Eastern Democratic Republic of Congo", *Behaviour Research and Therapy* 123 (2019): 103482.

30 We thank one of our anonymous peer reviewers for highlighting this point.

## Table 1. Types of interventions

| Name/label | Number of interventions identified in the RoE |
|---|---|
| Cognitive processing/behavioural therapy (CP/BT) | 15 |
| Psychosocial education | 7 |
| Individual support/counselling (including PTSD counselling) | 6 |
| Narrative exposure therapy (NET) | 6 |
| Combined psychosocial support | 5 |
| Group counselling | 4 |
| Interpersonal psychotherapy | 4 |
| Livestock/cash transfer | 4 |
| Social support/caregivers | 4 |
| Art-based therapy | 3 |
| Common elements treatment approach (CETA) | 3 |
| Child-friendly spaces | 2 |
| Couples therapy | 2 |
| Dance/movement-based therapy | 2 |
| Meditation | 2 |
| Teaching recovery techniques (TRT) | 2 |
| Theatre | 2 |
| Training | 2 |
| Acceptance and commitment therapy (ACT) | 1 |
| Behavioural activation therapy for depression (BATD) | 1 |
| Clinical therapy | 1 |
| Community trauma therapy | 1 |
| Eye movement desensitisation and reprocessing (EMDR) | 1 |
| Healing ceremonies | 1 |
| Music therapy | 1 |
| Sociotherapy | 1 |
| Sport-based therapy | 1 |
| Telemental health | 1 |
| Thought field therapy (TFT) | 1 |
| Treatment by repeating phrases of positive thoughts (TRPPT) | 1 |

## Figure 6. Intervention themes



policymakers' reluctance to fund studies that deploy traditional healers and non-professionals.

# 2. What works and what doesn't

Given the breadth and scope of trauma interventions reviewed here, the different methodologies used, the range of contexts and populations, and the uneven quality of research, it was challenging to identify what works to help conflict-affected people (both civilian and combatant) recover from trauma and reduce violence, and what doesn't. Our approach was to first identify what has been shown to work (or not work) in specific contexts and populations, and then to analyse the common elements that contribute to the effectiveness of these interventions. Table 2 summarises the most and least effective interventions. We also identified common elements that are potentially generalizable across diverse contexts and communities.

The emphasis is thus less on what works (i.e. specific interventions) and more on teasing out the elements and processes that contribute to effectiveness. The measurement of effectiveness and impact is explained in the Appendix.

## 2.1 Trauma-focused interventions

Twenty-eight studies (including one clinical trial for pharmacological treatment of children), or almost a third of all the studies reviewed, evaluated the impact of trauma-focused interventions (see Table 4). As a group, they represent the highest quality of studies analysed in this review; randomised, blinded, controlled, transparent, and 'culturally adapted' studies were considered high-quality. Many of the RCTs in this group were conducted in Iraq and DRC, suggesting that robust, high-quality studies can be conducted in FCAS. However, there is a need to build on the existing evidence base and to replicate successful studies in different contexts and with different populations.

**Table 2. Interventions that work and don't work**

| | |
|---|---|
| **Effective** | Group interpersonal therapy<br>Behavioural activation treatment for depression (BATD)<br>Teaching recovery techniques (TRT)<br>Training: Integration of external programme with local approaches (Rwanda)[31]<br>Common elements treatment approach (CETA)<br>Narrative exposure therapy (NET)<br><br>NB: No alternative and culturally-informed interventions, psychosocial or community-based interventions were deemed 'effective'. However, the notion of effectiveness reflects how the studies themselves were reported rather than the analysis of the reviewers. |
| **Promising** | Trauma-focused cognitive behavioural therapy (TF-CBT)<br>Cognitive processing therapy (CPT)<br>Music/arts/theatre/movement-based therapies<br>Stress reduction therapies<br>Sociotherapy<br>Livelihood support with trauma intervention/livestock asset provision<br>Couples therapy<br>Interpersonal therapy<br>Integrating local and external mental help approaches |
| **Mixed** | Livelihood support (alone)<br>Child-friendly spaces<br>Psychosocial support (in high schools) |
| **Ineffective** | Cash assistance (alone) |

31 A nine-day training program with psychoeducational and experiential components. It included the following sessions: Understanding Genocide, Understanding the Effects of Trauma and Victimisation and Paths to Healing, Sharing Painful Experiences in an Empathic Context, and Vicarious Traumatization.

Among the trauma-focused interventions reviewed, **NET, CPT/CBT, TRT, and CETA were reported to be the most effective treatments in terms of reducing PTSD, anxiety, and depression amongst participants**. Teaching recovery techniques (TRT) – a form of CBT – was also reported to be effective at reducing disassociation, PTSD, and depression.

Studies indicated that TRT may hold potential to reduce trauma symptoms for war-affected groups in a range of different contexts, including Iraq, Lebanon, and Palestine. For example, a TRT behavioural group intervention was found to reduce post-traumatic stress symptoms amongst conflict-affected Palestinian adolescents[32] and school children.

Other studies have evaluated TRT in adolescents in Baghdad[33] and (although outside the scope of this particular review) adolescents in secure accommodation in Scotland.[34] Participation in TRT was found to reduce PTSD, grief, and depression.

Nearly half of the 28 studies focused on adult participants, whilst eight conducted interventions with under-18s, and three combined both adults and children. Only two studies, in Burundi[35] and South Sudan,[36] specifically address effective therapeutic approaches. These were identified as including client centeredness, therapeutic alliance, active problem-solving, trauma-focused exposure, and family involvement.

### Table 4. Quality of reviewed trauma-focused studies

| | | Quality of evidence | | | |
|---|---|---|---|---|---|
| | | **High** | **Moderate** | **Low** | **Total** |
| **Impact** | Effective | Bolton et al. (2014)<br>Barron et al. (2016)<br>Barron et al. (2017)<br>Bass et al. (2013b)<br>Tol et al. (2020) | | | 5 |
| | Promising | O'Callaghan et al. (2013)<br>Hall et al. (2014)<br>S. Murray et al. (2018)<br>Robjant et al. (2019) | McMullen et al. (2013)<br>Köbach et al. (2017) | Gormez et al. (2017)<br>Viller Hansen et al. (2017)<br>L. Murray et al. (2018)<br>Acaturk et al. (2015)<br>Thieree et al. (2020)<br>Jala et al. (2020) | 10 |
| | Mixed | Mahmooth et al. (2018)<br>Weiss et al. (2015) | Bass et al. (2013a)<br>Seidi et al. (2020)<br>Jordans et al. (2012) | Schaal et al. (2009)<br>Onyut et al. (2005) | 7 |
| | Ineffective | | Bolton et al. (2007)<br>Nayak et al. (2019) | | 2 |
| | Inconclusive | | Jordans et al. (2013) | Mogga (2017)<br>Kurbitary et al. (2018) | 3 |
| **Total** | | 10 | 8 | 10 | 28 |

32 I. Barron, G. Abdallah, and U. Heltne, "Randomized Control Trial of Teaching Recovery Techniques in Rural Occupied Palestine: Effect on Adolescent Dissociation", *Journal of Aggression, Maltreatment & Trauma* 25, no. 9 (2016): 955–73.

33 N. Ali, T. Al-Joudi, and T. Snell, "Teaching Recovery Techniques to Adolescents Exposed to Multiple Trauma Following War and Ongoing Violence in Baghdad", *Arab Journal of Psychiatry* 30, no. 1 (2019): 25–33.

34 I. Barron, D. Mitchell, and W. Yule, "Pilot Study of a Group-Based Psychosocial Trauma Recovery Program in Secure Accommodation in Scotland", *Journal of Family Violence* 32, no. 6 (2017): 595–606. Whilst this study is outside the scope of the RoE, it is worth noting that behavioural monitoring during and after participation in TRT showed a reduction in aggressive behaviour compared to those on the waitlist. The study is one of the few that look specifically at the behavioural implications of a trauma intervention.

35 M. Jordans et al., "Implementation of a Mental Health Care Package for Children in Areas of Armed Conflict: A Case Study from Burundi, Indonesia, Nepal, Sri Lanka, and Sudan", *PLoS Medicine* 10, no. 1 (2013): e1001371.

36 M. Jordans et al., "Treatment Processes of Counseling for Children in South Sudan: A Multiple n = 1 Design", *Community Mental Health Journal* 49, no. 3 (2013): 354–67.

In terms of what doesn't work, if interventions are not timed correctly and take place in an unsupportive context, the evidence suggests that **trauma interventions can worsen trauma symptoms**. This is especially the case if CPT occurs prematurely, and if the intervention is delivered in a stressful environment: for example, where the venue is not perceived to be safe by participants.

Such a situation may exacerbate people's existing stress and trauma.[37] A balance must be achieved in terms of intervention timing – not too soon, not too late. Furthermore, depending on the cultural context, labelling an intervention as trauma-centred runs the risk of presenting trauma as a stigma, suggesting that the intervention targets 'mad people'. When they become attached to interventions, such labels can lead to further stigma and prevent people from seeking help.

> **Labelling interventions 'psychological', or if participants think they are being labelled 'mad', may result in interventions being ineffective, or worse, doing more harm than good.**

Acarturk et al. suggest that stigma is not only related to trauma causes/events and symptoms, but that **receiving treatment can also be a source of community and group-level stigma**.[38] Their study indicates that Syrian refugees in Turkey who were being treated for trauma with eye movement desensitisation and reprocessing therapy (EMDR) preferred to hide the fact that they were receiving treatment. Some reported fears that the treatment itself would result in them becoming insane. In other words, pathologising normal and adaptive responses to extreme stress risks stigmatising and retraumatising people. Labelling interventions 'psychological', or if participants think they are being labelled 'mad', may result in interventions being ineffective or, worse, doing more harm than good.

The key findings from the main types of trauma interventions (NET and CPT/CBT/CETA) are discussed below.

### 2.1.1 NET

Five of the trauma-focused intervention studies used some form of NET, including KIDNET (for children) and FORNET (NET developed for violent offenders). It is noteworthy that there has been criticism that NET, which was developed in Germany, is overly individual-centred[39] and may be incompatible in cultures that are more reliant on mutuality and togetherness.

However, there is optimism among other scholars that these interventions can be adapted and group-centred activities added. For example, amongst ex-combatant populations in DRC, both Robjant et al. and Köbach et al. used FORNET but also employed interpersonal therapy in group settings.[40] Both studies show promise. Evaluations revealed that NET interventions reduced reported levels of depression and PTSD among participants. In Robjant et al.'s study, pro-social behaviour and the quality of relationships reportedly increased. Schaal et al. also found that individual NET sessions were more effective than group adaptations of interpersonal psychotherapy in Rwanda.[41] In Uganda, Onyut et al. used KIDNET and found that after just four sessions of

37 S. Thierrée et al., "Trauma Reactivation under Propranolol among Traumatized Syrian Refugee Children: Preliminary Evidence Regarding Efficacy", European *Journal of Psychotraumatology* 11, no. 1 (2020): 1733248.

38 C. Acarturk et al., "EMDR for Syrian Refugees with Posttraumatic Stress Disorder Symptoms: Results of a Pilot Randomized Controlled Trial", *European Journal of Psychotraumatology* 6, no. 1 (2015): 27414.

39 J. Lely et al., "The Effectiveness of Narrative Exposure Therapy: A Review, Meta-Analysis and Meta-Regression Analysis", *European Journal of Psychotraumatology* 10, no. 1 (2019): 1550344.

40 Robjant et al., "The Treatment of Posttraumatic Stress"; and A. Köbach et al., "Psychotherapeutic Intervention in the Demobilization Process: ddressing Combat-Related Mental Injuries with Narrative Exposure in a First and Second Dissemination Stage", *Clinical Psychology & Psychotherapy* 24, no. 4 (2017): 807–25.

41 Schaal et al., "Narrative Exposure Therapy".

exposure, participant scores on intrusion[42] and avoidance had reduced.[43] Finally, Viller Hansen et al.'s multi-country evaluation of NET interventions for torture victims in MENA found a strong positive effect of NET in an Arab cultural setting, perhaps due to its applicability to cultures that share an oral narrative tradition.[44]

### 2.1.2 CPT, CBT, and CETA

The studies on CPT indicated that the intervention can be adapted to suit different contexts and populations, and that its impact may be felt in participants' social and economic networks. In DRC, Bass et al. found that group-based CPT was more effective than individual support in reducing PTSD symptoms and combined depression and anxiety symptoms,[45] and improved functioning. Whereas two studies by Bass and colleagues [46] measured clinical outcomes from CPT, Hall et al. employed a social capital perspective in their evaluation of CPT on victims of sexual violence in eastern Congo.[47]

Yet, much of the literature evaluating outcomes of mental health treatment for rape survivors focuses on reductions in mental health symptoms, not on social networks/social functioning. CPT was shown to increase individual-level structural social capital and emotional support-seeking[47]. This provides some insight into how a trauma intervention may have a wider impact beyond the clinical domain. Despite measuring social capital in a predominantly narrow way (limited to structural aspects),[48] Hall's study is important because it illustrates the relationship between social networks/capital, improved mental health, and emotional support-seeking for a specific group of women in DRC. CPT has also been employed in Iraq, but it was found to be less effective than CETA.[49]

Trauma-focused interventions such as CPT, CBT, and NET have been criticised for being individualised treatments that do not reflect the collectivist cultures in which they are implemented.[50] However, studies have employed CPT and CBT in group contexts, and NET treatments included group-centred interpersonal therapy discussions. Despite the relatively robust evidence base for CPT and CETA,[51] studies have not been replicated in different countries and with different populations. For example, CPT was found to be more successful in DRC, yet in Iraq, CETA was more effective than CPT. To the best of our knowledge, CETA has not been trialled in DRC. In other words, it is difficult to know which intervention works best, which suggests that different outcomes in different countries may demonstrate conflicting data rather than lack of data.[52]

## 2.2 Training of community health workers

Six studies examined training of community/local health workers (see Table 5). One of the main barriers to the implementation of trauma interventions in FCAS is the shortage of mental health specialists. The recognition of this scarcity has led to 'task-shifting' approaches, which are used to train non-specialist workers in Western

42 Intrusion refers to unwanted and upsetting memories, nightmares, flashbacks, and emotional distress and/or physical reactivity after exposure to reminders.

43 L. Onyut et al., "Narrative Exposure Therapy as a Treatment for Child War Survivors with Posttraumatic Stress Disorder: Two Case Reports and a Pilot Study in an African Refugee Settlement", *BMC Psychiatry* 5, no. 1 (2005): 1–9.

44 Viller Hansen et al., "Impact of NET on Torture Survivors".

45 This is also known as mixed depression and anxiety symptoms. People who suffer from both anxiety and depression might not meet the criteria for specific depressive or anxiety disorders, but they may have symptoms of limited or equal intensity. See, for example, J. Spijker et al., "Who is MADD? Mixed Anxiety Depressive Disorder in the General Population", *Journal of Affective Disorders* 121, no. 1–2 (2010): 180–83.

46 J. Bass et al., "Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence", *New England Journal of Medicine* 368, no. 23 (2013): 2182–91; and Bass et al., *Addressing Sexual Violence*. §v

47 Hall et al., "The Effect of Cognitive Therapy".

48 Structural aspects of social capital refer to time spent in non-kin social network, group membership, and participation, and the size of financial and instrumental support networks.

49 Weiss et al., "Community-Based Mental Health Treatments".

50 C. Torre, "Psychosocial Support (PSS) in War-Affected Countries: A Literature Review", Politics of Return Working Paper No. 3 (London School of Economics and Political Science, 2019).

51 See CETA Global, https://www.cetaglobal.org/

52 We thank one of the anonymous reviewers for drawing our attention to this.

**Table 5. Quality of reviewed studies on training for community health workers**

| | | Quality of evidence | | | |
|---|---|---|---|---|---|
| | | High | Moderate | Low | Total |
| Impact | Effective | Staub et al. (2005) | | | 1 |
| | Promising | | Jacob et al. (2014)<br>Neuner et al. (2008)<br>Borisova et al. (2013) | | 3 |
| | Mixed | | | Chemali et al. (2018) | 1 |
| | Ineffective | | | | |
| | Inconclusive | | | Almoshmosh et al. (2020) | 1 |
| Total | | 1 | 3 | 2 | 6 |

approaches to mental health. The studies in this review indicated optimism that **community health workers can be trained to deliver modified versions of CBT, CPT, and NET**. Reviewed evidence from the implementation of RCTs in Rwanda and DRC, for example, demonstrates that local NET therapists successfully employed a train-the-trainer model.[53] Indeed, WHO has endorsed this kind of 'mixed' approach for some time.[54]

However, Nayak et al. sound a note of caution,[55] suggesting that community-based approaches (i.e. those that train local community health workers) may not always be effective when treating severe psychopathology after large-scale violence. Their study, set in Rwanda in 1995, examined whether children in unaccompanied children's centres (UCCs or orphanages) with staff trained in trauma alleviation methods had lower levels of post-traumatic stress symptoms than children in orphanages staffed by individuals who lacked any formal mental health training. Interventions showed no signs of improving these symptoms, and in some cases the prevalence of reported systems actually increased.

However, it may be that the relationships, space, and timing of the intervention were inappropriate. It is possible that the counsellors themselves were dealing with trauma and were thus unable to develop the deeper relationships with the children that are required for a treatment to be successful. Perhaps the venue and timing of the intervention – an orphanage in the immediate aftermath of the Rwandan genocide – was simply not conducive to a therapy of this nature. Moreover, the sequencing/timing of the intervention was not optimal. The children were immediately encouraged to speak about their memories of the genocide, and what had happened to them and their parents. This might have been too much, too soon.[56]

One of the key learning points identified in this RoE (a point that connects promising and effective interventions) is the importance of active engagement and inclusion of local health workers. Staub demonstrates that if and when local staff are trained in Western treatments but are actively encouraged to integrate aspects of these approaches into their own usual practices, the intervention is more successful than if they are not. In the study, some of the staff recruited to deliver interventions were preachers who included prayer and worship in the intervention. One of the benefits of using local staff is that they can contribute to filling the mental health care gap in many FCAS.[57]

53 N. Jacob et al., "Dissemination of Psychotherapy for Trauma Spectrum Disorders in Post Conflict Settings: A Randomized Controlled Trial in Rwanda", *Psychotherapy and Psychosomatics* 83, no. 6 (2014): 354–63; and F. Neuner et al., "Treatment of Posttraumatic Stress Disorder by Trained Lay Counselors in an African Refugee Settlement: A Randomized Controlled Trial", *Journal of Consulting and Clinical Psychology* 76, no. 4 (2008): 686–94.

54 This is a point emphasised by one of our anonymous reviewers. See, for example, World Health Organization, *Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches* (2021).

55 Nayak et al., "Trauma Alleviation Treatment".

56 *Ibid.*

57 E. Staub, "Promoting Healing and Reconciliation in Rwanda, and Generating Active Bystandership by Police to Stop Unnecessary Harm by Fellow Officers", *Perspectives on Psychological Science* 14, no. 1 (2019): 60–64.

Local staff are critical to the success of interventions not just because of their instrumental capacity. Intermediaries may also act as bridges and conduits between external (generally Western) clinical practitioners and researchers and the local population. They are shown to be helpful in assisting researchers to 'culturalise' some elements of the treatment. If they are given the space and opportunity, they can also 'translate' some of the treatments for participants. In several cases, local counsellors were able to enhance the therapy because they could empathise with the participants over shared experiences of violence and trauma. This helped to strengthen the bond between counsellor and client. On the other hand, strictly following manuals, rote delivery, and adopting a moralistic or lecturing mode of delivery were found to reduce the effectiveness of interventions.

Chemaliet et al.'s study[58] is one of the few to address the issue of vicarious trauma – the impact of trauma on local counsellors and mental health workers. In Lebanon, a stress management relaxation response training (SMART) proved effective in assisting fieldworkers to become aware of their own negative emotions and to think more positively. Such programmes may prove costly and time-consuming for organisations already stretched and lacking resources. However, in such circumstances it is worth considering the mental health burden (and potential for trauma) that health workers in FCAS are placed under. It is important to ensure that organisations provide adequate support systems, whether through group discussions/sharing of problems or by supporting the development of a buddy system.

Cultural adaptation is mentioned in passing in a number of studies, yet it is rarely explored in depth. One important exception to this is Bolton et al., who show that Western therapies can be delivered effectively by community health workers (CHWs). CHW-delivered CPT and behavioural activation treatment for depression (BATD) reduced depressive symptoms and functional impairment among torture survivors in the Kurdish region of Iraq.[59]

A separate publication discusses how the BATD approach was adapted and delivered by CHWs using the assessment–decision–adaptation–production–topical experts–integration–training–testing (ADAPT–ITT) method.[60] The paper discusses cultural modification, how BATD was adapted to low-literacy contexts and tailored to non-specialist workers. Adaptations are described as iterative, conducted in conjunction with CHWs and on-site managers. However, the views of local communities and local populations regarding feasibility and/or applicability of such treatments were not taken into consideration. CHWs do not necessarily represent the culture or community they work in.

## 2.3 Psychosocial interventions

Seventeen studies chosen for review employed group-level interventions in the form of psychosocial education,[61] interpersonal counselling sessions,[62] or stress management techniques.[63] These interventions focused on specific groups of trauma- or conflict-affected individuals. They centred on specific relationships (e.g. couples)[64] or unspecified groups (where it

58 Z. Chemali et al., "Reflections from the Lebanese Field: 'First, Heal Thyself'", *Conflict and Health* 12, no. 1 (2018).

59 P. Bolton et al., "A Randomized Controlled Trial of Mental Health Interventions for Survivors of Systematic Violence in Kurdistan, Northern Iraq", *BMC Psychiatry* 14 (2014): 360.

60 J. Magidson et al., "Adaptation of Community Health Worker-Delivered Behavioral Activation for Torture Survivors in Kurdistan, Iraq", *Global Mental Health* 2 (2015).

61 See E. Eiling et al., "Psychosocial Support for Children in the Republic of South Sudan", *Intervention* 12, no. 1 (2014): 61–75; Stepakoff et al., "Trauma Healing"; and C. Panter-Brick et al., "Insecurity, Distress and Mental Health: Experimental and Randomized Controlled Trials of a Psychosocial Intervention for Youth Affected by the Syrian Crisis", *Journal of Child Psychology and Psychiatry* 59, no. 5 (2018): 523–41.

62 See L. Gupta and C. Zimmer, "Psychosocial Intervention for War-Affected Children in Sierra Leone", *British Journal of Psychiatry* 192, no. 3 (2008): 212–16; P. Yeomans et al., "A Randomized Trial of a Reconciliation Workshop with and without PTSD Psychoeducation in Burundian Sample", *Journal of Traumatic Stress* 23, no. 3 (2010): 305–12; J. Bass et al. "Group Interpersonal Psychotherapy for Depression in Rural Uganda: 6-month Outcomes: Randomised Controlled Trial", *British Journal of Psychiatry* 188 (2006): 567–73; and N. Budosan et al., "Evaluation of One Mental Health/Psychosocial Intervention for Syrian Refugees in Turkey", *International NGO Journal* 11, no. 2 (2016): 12–19.

63 F. Mughairbi, A. Abdulaziz Alnajjar, and A. Hamid, "Effects of Psychoeducation and Stress Coping Techniques on Posttraumatic Stress Disorder Symptoms", *Psychological Reports* 123, no. 3 (2020): 710–24.

64 E. Morgan et al., "The Development and Implementation of a Multi-Couple Therapy Model with Torture Survivors in the Democratic Republic of the Congo", *Journal of Marital and Family Therapy* 44 (2018): 235–47.

**Table 6. Quality of reviewed psychosocial intervention studies**

| | | Quality of evidence | | | |
|---|---|---|---|---|---|
| | | High | Moderate | Low | Total |
| Impact | Effective | Bass et al. (2003) | | | 1 |
| | Promising | Betancourt et al. (2014) | Budosan et al.(2016)<br>Bass et al. (2016) | Mercy Corps (2016)<br>Morgan et al. (2018)<br>Stepakoff et al. (2006)<br>Gupta & Zimmer (2008)<br>Eiling et al. (2014) | 7 |
| | Mixed | Panter-Brick et al. (2018) | | Save the Children (2014) | 2 |
| | Ineffective | Tol et al. (2014) | | | 1 |
| | Inconclusive | | Yeomans et al. (2010)<br>Dix-Peek et al. (2018)<br>Lekskes et al. (2007) | Mughairbi et al. (2020)<br>Metzler et al. (2015)<br>Steinhilber (2019) | 6 |
| Total | | 3 | 5 | 9 | 17 |

was unclear what relationship was present in the group before, during, and after treatment).

In general, these studies were found to be lacking quality and effectiveness compared to other intervention themes. Nine out of 17 studies were of low quality (see Table 6) and point to the need to ensure that psychoeducation reflects and adapts to cultural norms and expectations regarding trauma. For example, in Rwanda, Tol et al. found that PTSD psychoeducation exacerbated trauma symptoms because the school-based intervention induced an expectation that trauma exposure was debilitating.[65]

Nevertheless, there are some promising interventions. Betancourt et al. conducted an RCT of a 10-session, group-based youth readiness intervention (YRI) in Sierra Leone. This programme contained elements of both CBT and interpersonal psychotherapy and was delivered by lay health workers. Compared to a waitlist control group, the treatment reportedly led to improved emotional regulation skills, pro-sociality, functioning, social support, teacher-rated school attendance, classroom behaviour, and school retention.[66]

Only one study in this category was effective,[67] whilst seven others were deemed promising. We found couples-based therapy for torture victims in DRC particularly promising, despite the small sample size.[68] This suggests that interventions involving specific sets (or dyads) of family-based relationships (husband-wife, parent-child) may be particularly effective because they situate the intervention within existing hyper-local networks.

## 2.4 Alternative and culturally informed interventions

Compared to other themes, the 10 studies which looked at alternative and culturally informed interventions were generally of low quality, but all of them were still considered promising (see Table 7). Nine employed dance,[69] arts,[70]

65 W. Tol et al., "School-Based Mental Health Intervention for Children in War-Affected Burundi: A Cluster Randomized Trial", *BMC Med* 12 (2014): 56.

66 Betancourt et al., "A Behavioral Intervention".

67 P. Bolton et al., "Group Interpersonal Psychotherapy for Depression in Rural Uganda: A Randomized Controlled Trial", *Jama 289*, no. 23 (2003): 3117–24.

68 E. Morgan et al., "The Development and Implementation of a Multi-Couple Therapy Model with Torture Survivors in the Democratic Republic of the Congo", *Journal of Marital and Family Therapy* 44 (2018): 235–47.

69 Harris, "Pathways to Embodied Empathy".

70 N. Ugurlu, L. Akca, and C. Acarturk, "An Art Therapy Intervention for Symptoms of Post-Traumatic Stress, Depression and Anxiety among Syrian Refugee Children", *Vulnerable Children and Youth Studies* 11, no. 2 (2016), 89–102; B. Hakki, "Using Art tools with Older Syrian Refugee Women to Explore Activated Development", *Intervention* 16 (2018), 87–94; and D. Abdulah and B. Abdulla, "Suicidal Ideation and Attempts Following a Short-Term Period of Art-Based Intervention: An Experimental Investigation", *The Arts in Psychotherapy* 68 (2020).

**Table 7. Quality of reviewed studies on alternative and culturally informed interventions**

| | | Quality of evidence | | | |
|---|---|---|---|---|---|
| | | High | Moderate | Low | Total |
| **Impact** | Effective | | | | 0 |
| | Promising | | | d'Ardenne & Kiyendeye (2015)<br>Rees et al. (2014)<br>Ugurlu et al. (2016)<br>Stark (2006)<br>Harris (2007)<br>Hakki (2018)<br>Staempfli et al. (2017)<br>Yüksek (2018)<br>Abdulah & Abdulla (2020) | 7 |
| | Mixed | | | Alshughry (2018) | 1 |
| | Ineffective | | | | |
| | Inconclusive | | | | |
| **Total** | | | | 10 | 10 |

music,[71] theatre,[72] meditation,[73] and sports-based therapies,[74] whilst one involved traditional healing ceremonies in Sierra Leone.[75] The findings suggest that **culturally informed interventions worked by first providing vital opportunities for participants to develop new social relationships and new social networks, and second, by facilitating 'flow'.**

Flow refers to a mental state in which a person is fully engaged in a task. Research has shown that for people with depression or violence-related trauma, experiencing flow through sport and other activities helps to increase well-being and decrease negative feelings.[76] In other words, taking part in activities such as art, sport, or dance provides the opportunity for those affected by trauma to have a much-needed mental break from intrusive thoughts and painful memories. However, unlike trauma-focused interventions, these interventions lack a robust evidence base. Further research is needed to compare these relatively common interventions with more established mainstream ones.

Studies in this intervention theme represent some of the lowest quality of assessments/evidence in that they did not use control groups, had only a small number of participants, and lacked randomisation. Four of the studies employed a purely qualitative research methodology. All the studies included may have author bias in that the authors designed the interventions and then evaluated the outcomes. Moreover, these interventions have not been replicated or reproduced in other areas or with other populations. Several systematic reviews highlight this issue. Pedersen et al. point out that in many settings, traditional healing practices make critical contributions to social healing in the context of war.[77]

However, these tend to be undervalued and overshadowed by other treatment strategies

71 d'Ardenne and Kiyendeye, "An Initial Exploration".

72 C. Yuksek, "Dealing with Stress Using Social Theatre Techniques with Young Syrian Students Adapting to a New Educational system in Turkey: A Case Study", *Intervention* 16 (2018), 175–80; and U. Alshughry, "Non-Violent Communication and Theatre of the Oppressed: A Case Study with Syrian Refugee Women from the Kareemat Centre in Turkey", *Intervention* 16, no. 2 (2018): 170–74.

73 B. Rees et al., "Significant Reductions in Posttraumatic Stress Symptoms in Congolese Refugees within 10 days of Transcendental Meditation Practice", *Journal of Traumatic Stress* 27, no. 1 (2014): 112–15.

74 F. *Staempfli and D. Matter, Exploring the Impact of Sport and Play on Social Support and Mental Health: An Evaluation of the "Women on the Move" Project in Kajo-Keji, South Sudan. Swiss Academy for Development, 2017.* https://sad.ch/en/news-media/publications/women-on-the-move-research-paper/

75 L. Stark, "Cleansing the Wounds of War: An Examination of Traditional Healing, Psychosocial Health and Reintegration in Sierra Leone", *Intervention 4*, no. 3 (2006): 206–18.

76 C. Ley et al., "Exploring Flow in Sport and Exercise Therapy with War and Torture Survivors", *Mental Health and Physical Activity* 12 (2017): 83–93.

77 Pedersen et al., "Searching for Best Practices".

that may be easier to measure and understand (from a Western donor and research perspective). Betancourt et al. find that "[m]ost research on traditional healing/cleansing ceremonies has been descriptive. No systematic evaluations have examined the degree to which communities and traditional healing interventions are associated with improvements in mental health in war-affected children and adolescents."[78]

Despite the low evidence base supporting the efficacy of culturally informed interventions, it is important to examine more rigorously the value of engagement with local, traditional, religious, and political belief systems. Such research would help expand the evidence base regarding the processes, mechanisms, and actors that are already in use among conflict-affected populations, where programme interventions could then work to support and amplify these and ensure that they are sustainable.

## 2.5 Community-centred interventions

Nine studies assessed the reported outcomes of community-centred interventions (see Table 8). These studies measured a wider range of outcomes that included social cohesion, economic outcomes, and community acceptance. Four interventions involved livelihood support and cash or livestock transfers. However, **cash transfers alone were reported to be ineffective in reducing trauma symptoms and meeting household needs.**

Falb et al. found that short-term cash assistance to Syrian women in Raqqa actually increased participants' depressive symptoms and resulted in no changes to their perceived level of household need and daily stressors, despite cash assistance being viewed favourably by female participants.[79] Conversely, a livestock asset transfer programme carried out in DRC led to a decrease in participants' anxiety and depression, and an increase in economic resources; participants also reported a reduction in intimate partner violence (IPV).[80] Different contextual factors and the limited number of studies available make it difficult to draw firm conclusions, but these studies do suggest that focusing on asset transfers rather than cash transfers may be effective in alleviating a range of economic and behavioural challenges.

Only one study did not explicitly set out to reduce trauma and had no diagnostic criteria for participation.[81] It was a large-scale psychosocial intervention conducted in post-genocide Rwanda and primarily aimed at social bonding. Carried out in the community and led by local staff, it involved debates and opportunities for participants to exchange experiences and

**Table 8. Quality of reviewed studies on community-centred interventions**

| | | Quality of evidence | | | |
|---|---|---|---|---|---|
| | | **High** | **Moderate** | **Low** | **Total** |
| **Impact** | Effective | | | | |
| | Promising | | Scholte et al. (2011)<br>Ertl et al. (2011)<br>Glass et al. (2017)<br>Ziveri et al. (2019) | Acosta et al. (2018)<br>Womersley & Arikut-Treece (2019) | 6 |
| | Mixed | | Amisi et al. (2018)<br>Muller et al. (2017 | | 2 |
| | Ineffective | Falb et al. (2020) | | | 1 |
| | Inconclusive | | | | |
| **Total** | | 1 | 6 | 2 | 9 |

78 Betancourt et al., "A Behavioral Intervention", 14.

79 K. Falb et al., "Cash Assistance Programming and Changes over Time in Ability to Meet Basic Needs, Food Insecurity and Depressive Symptoms in Raqqa Governorate, Syria: Evidence from a Mixed Methods, Pre-Posttest", *PloS One* 15, no. 5 (2020).

80 C. Amisi et al., "The Impact of Support Programmes for Survivors of Sexual Violence: Micro-Level Evidence from Eastern Democratic Republic of the Congo", *Medicine, Conflict and Survival* 34, no. 3 (2018), 201–23.

81 W. Scholte et al., "The Effect on Mental Health of a Large Scale Psychosocial Intervention for Survivors of Mass Violence: A Quasi-Experimental Study in Rwanda", *PLoS One* 6, no. 8 (2011): e21819.

coping strategies, as well as engage in games and exercises. The authors found that reported mental health symptoms improved naturally over time, but that those in the intervention group displayed greater improvement during and after the intervention. This effect was reported by the authors as particularly significant for women. What is worth emphasising here is that even non-trauma interventions may have a positive impact on mental health.

What emerges from this review is that most trauma interventions do not measure outcomes broadly or holistically. Equally, standard 'peacebuilding and conflict resolution' interventions such as transitional justice, truth and reconciliation commissions, security sector reforms, local mediation mechanisms, and livelihood provision initiatives often do not consider or measure their impact on either trauma or behaviour at the household or community level.

## 2.6 Common elements

A number of common elements run through the different interventions identified in this review. They can help explain why some interventions are more effective than others.

- **Relationships play a critical role in helping or hindering recovery from trauma.** Regardless of whether an intervention is individual- couple-, community-, or group-based, the quality and type of relationships that develop between participants during the treatment is critical to its efficacy. Equally important is the relationship that develops between counsellors and those who are receiving the intervention. In this respect, we find that interventions are more successful at reducing trauma symptoms when:

  a. they provide individuals with access to alternative forms of support beyond their immediate family/friendship group
  b. they strengthen existing relationships (e.g. between partners, or children and parents).

What mattered most in determining the effectiveness of an intervention was **not the type of intervention but rather who conducted it and how it was developed and implemented.**

- Any opportunity for people to **socialise, meet, be listened to, and share experiences and advice in a safe space** can alleviate some of the feelings of isolation, anxiety, and depression experienced by traumatised people. However, this can only work if it occurs between people who have shared similar experiences of violence and trauma.

- **Ensuring programmes match beneficiaries' perceived needs is critical.** For example, O'Callaghan et al.'s evaluation of NET and CPT found that most participants did not want to talk about past war experiences;[82] instead, they wanted to earn money so that they could pay their children's school fees. A report by IOM on South Sudan found that dedicated guidance counselling services did not emerge as a necessity at the individual or family level, but rather at the community level.[83] This suggests that 'local' priorities are not as focused on the individual sphere as they are on the social one, where most of the post-conflict healing processes take place. What matters to external development/aid actors and agencies might not reflect what matters most to local populations. By concentrating only on trauma-focused interventions, we risk neglecting what conflict-affected populations really feel they need.

- Interventions that **build social support and cohesion**, and that **adopt and synthesise local approaches, knowledge, and actors**, are more effective than those that do not.

82 P. O'Callaghan et al., "A Randomized Controlled Trial of Trauma-Focused Cognitive Behavioural Therapy", *Journal of the American Academy of Child and Adolescent Psychiatry* 52.4 (2013), 359–69; Torre, "Psychosocial Support".

83 IOM, Manual on Community-based Mental Health and Psychosocial Support in Emergencies and Displacement, 2019. https://www.iom.int/sites/g/files/tmzbdl486/files/mhpss/v3_-_manual_on_cb_mhpss_in_emergencies_and_displacement.pdf

# 3. Limitations and evidence gaps

This section identifies key limitations and evidence gaps uncovered by the review. The evidence gaps examined in detail comprise:

- lack of holistic framing to measure outcomes of trauma interventions among conflict and war-affected communities
- lack of integration of culturally and contextually relevant approaches
- lack of robust evaluation methods and measurement tools
- missing populations and gender biases.

The section then discusses why it is important to include missing populations in trauma-related interventions. These potential participants include minorities, people with disabilities, families of members of terrorist organisations, soldiers, prisoners, and members of non-state armed groups.

## 3.1 Limitations

Overall, the evidence base for what helps individuals and groups recover from trauma in FCAS is fragmented in terms of both interventions and cross-cutting limitations. Causality is challenging to ascertain, and a number of authors state explicitly that it is difficult to know 'which bit' of the treatment accounts for the reported trauma reduction, and why. Interventions are rarely synthesised across countries or different populations and organisations. In other words, there is little replication of studies that work in different countries and with different populations. With the exception of Iraq, there also appears to be limited engagement or coordination by national-level actors.

Various key conceptual and empirical limitations emerge from this RoE. Overall, **nuanced understanding and recognition of the heterogeneity of actors, approaches, and relationships that shape the causes of, and solutions to, trauma in FCAS on the part of policymakers, are limited**. This may undermine the efficacy and sustainability of interventions because programmes are rarely designed, implemented, and evaluated with cultural nuance in mind. For example, many of the papers mention cultural adaptation and its importance. However, only one discusses a psychosocial intervention that was co-developed with local experts and involved traditional healers/leaders.[84]

Few studies explain what cultural adaptation entails, how it can be achieved, and what adopting it might involve. In addition, how trauma is understood and how successful outcomes are measured are likely to vary considerably depending on cultural context and the extent to which a society or community is individualist or collectivist. Whilst there are well-established measurements for trauma that can be culturally adapted, they are often 'our' (i.e. Western/Euro-American) yardstick and reflect unconscious Western framings and views of trauma. What we need is a better understanding of attitudes surrounding trauma, violence, and aggression in FCAS, as well as to disaggregate different levels of exposure and participation.

Second, the literature emphasises and recommends a community-based approach. However, few studies elaborate on what that entails in practical terms. Who is the 'community'? What kinds of resources, actors, and institutions (formal and informal) are present in communities? What divisions exist within communities that affect post-conflict experiences? What types of pre-existing resources do individuals and groups have access to, and how can they be utilised to support mental health?

A further key limitation is neglect of how **micro, meso, and macro level dynamics and**

84 Stepakoff et al., "Trauma Healing".

**leadership interconnect to shape the context in which trauma can be ameliorated**. All the studies reviewed here are micro level studies about particular, discrete phenomena. The studies placed insufficient attention on how local dynamics (drivers, actors, relationships, and institutions) connect to the meso and macro levels. Absent from the analysis are acknowledgements of local power dynamics and how they shape the governance and security context in which interventions occur. There is little consideration of the role local, regional, and national political-military elites play not only in conflict but also in the perpetration of trauma, and how the negative effects of trauma can be dealt with.

Furthermore, even within the same country (such as Iraq) there seems to be little evidence that there is an overarching, coherent mental health strategy which programmes and policies can support. In areas beset by violence and instability, populations and their leaders will have witnessed, perpetrated, and been the victims of traumatic violence at multiple levels and over multiple periods of time. Whilst a handful of studies hint at the importance of encouraging the inclusion or 'buy-in' of mid-level civilian or religious leaders (local/community or camp leaders, for example), the actual dynamics of such practices are rarely discussed in detail. There is a dearth of studies that seek to engage, integrate, and better understand the role of local leaders of all forms – military/security, economic, political, religious, or 'big men' – in trauma interventions. Finally, there is a lack of attention placed on understanding how individual interventions impact group and community dynamics, and conversely, how group or community interventions impact the individual.

## 3.2 Evidence gaps

### 3.2.1 Lack of holistic framing to measure outcomes of trauma interventions

- The review revealed little **comparative analysis of trauma interventions from a behavioural perspective**. Few studies explore the effect of trauma interventions on different types of violent or peaceful behaviour and norms. A handful of community-centred interventions in FCAS – such as sociotherapy, livelihoods provision, cash and livestock transfers – examine outcomes from a social cohesion perspective, but they do not reflect rigorous, systematic analyses.[85] The only study found to evaluate the impact of a trauma intervention through the lens of social capital (CPT for rape survivors in DRC) focused on individual rather than group level evaluation, and only measured four structural aspects rather than employing a broader, more holistic range of relational, emotional, and psychosocial analyses.[86]

- **The majority of trauma interventions examined lacked multidisciplinary, multidimensional measurement outcomes**.[87] For example, none of the studies measured outcomes based on changes to attitudes, narratives, and memories; nor did they measure changes to the structure, characteristics, and gender dynamics of social networks. By the same token, standard 'peacebuilding and conflict resolution' interventions (transitional justice, truth and reconciliation commissions, security sector reforms, local mediation, and livelihoods provision) do not generally measure effects at the household or community level.

- **Disarmament, demobilisation, and reintegration (DDR) studies undervalue the psychosocial needs of rebels, militias, and paramilitaries in the recovery process**. These studies often examine short-term impacts and focus on one macro-indicator: whether DDR prevents a return to violence or war. At the community level, the emphasis has been on stopping remobilisation by addressing group grievances and 'buying peace' through local elites. Prominence is given to political needs (control over ministries), security needs (allowing groups to retain militias), and economic needs (livelihoods, cash for guns). Among the studies

85 Falb et al., "Cash Assistance Programming"; Amisi et al., "The Impact of Support Programmes"; Scholte et al., "The Effect on Mental Health".

86 Hall et al., "The Effect of Cognitive Therapy".

87 *Ibid.*

there is less focus on individual recovery or well-being[88] or reconciliation, and only a nascent evidence base examining the connections between a past as a violent perpetrator and future appetite for violence.[89] Social and psychosocial needs – among combatants and non-combatants – have not been prioritised, although they have been linked in the wider literature to remobilisation of combatants, and as such may be critical to understanding other types of post-conflict violence.[90]

### 3.2.2 Integration of culturally and contextually relevant approaches

- **Western (i.e. American/European) assumptions, knowledge, and practices dominate.** The studies reviewed often indicate a mismatch between the intervention tested and the stated preferences, needs, or norms of the target population.[91] This disconnect highlights the possibility that donor imperatives and Western approaches to conflict and trauma recovery do not always reflect what matters most to local populations. It also underlines the importance of evaluating existing local mechanisms that may align with community norms and values. For example, out of the 95 studies examined, only two explored the impact on trauma recovery of traditional practices such as dance or healing ceremonies.[92] Similarly, there is a substantial literature on wartime trauma and PTSD from psychiatrists and psychologists, but these studies have largely focused on veterans from OECD countries.[93] There is little comparative literature on PTSD and trauma on veterans from low-income countries.
- **Lack of norms-based cultural adaptation.** The importance of culturally appropriate programmes was highlighted in all studies. However, only one study discusses psychosocial interventions that were developed and administered locally.[94] Indeed, few studies explain what cultural adaptation entails and how it can be achieved.[95] Better understanding and evidence are needed of local, contextual characterisations of norms surrounding trauma, violence, and aggression.

### 3.2.3 Robust evaluation methods and measurement tools across interventions

- **Lack of longitudinal studies**. Follow-up was generally only conducted three to six months after an intervention (if at all). This makes it almost impossible to evaluate the long-term effects of interventions.

> **“...Disarmament, demobilisation, and reintegration (DDR) studies undervalue the psychosocial needs of rebels, militias, and paramilitaries in the recovery process...**

- **Lack of a robust evidence base**. Community-based interventions often lacked a control group and randomisation and were conducted among small populations without replication in other contexts. For example, no experiments or RCTs compared Western-style interventions against culturally embedded/norms-based traditional/

88 A. Brettle, *Social Networks and the Post-Conflict Transitions of Ex-Combatants in Rwanda*, King’s College London, 2019.

89 A. Köbach et al., “Violent Offending Promotes Appetitive Aggression Rather than Posttraumatic Stress – A Replication Study with Burundian Ex-Combatants”, *Frontiers in Psychology* 6.1755 (2015).

90 See, for example, O. Kaplan and E. Nussio, “Explaining Recidivism of Ex-Combatants in Colombia”, *Journal of Conflict Resolution* 62, no. 1 (2018): 64–93; and A. Themnér, *Violence in Post-Conflict Societies: Remarginalization, Remobilizers and Relationships* (Routledge, 2011).

91 P. O’Callaghan et al., “Trauma-Focused Cognitive Behavioural Therapy”

92 Stark, “Cleansing the Wounds of War”; Harris, “Pathways to Embodied Empathy”.

93 See M. Jakupcak et al., “Anger, Hostility, and Aggression among Iraq and Afghanistan War Veterans Reporting PTSD and Subthreshold PTSD”, *Journal of Traumatic Stress* 20, no. 6 (2007): 945–54; and J. Bremner et al., “Chronic PTSD in Vietnam Combat Veterans: Course of Illness and Substance Abuse”, *American Journal of Psychiatry* 153, no. 3 (1996), 369–75.

94 Stepakoff et al., “Trauma Healing”.

95 An important exception is Bolton et al. (2014), who showed the efficacy of two CHW-delivered interventions (CPT and BATD) in reducing depressive symptoms and functional impairment among torture survivors in the Kurdish region of Iraq. A separate publication by Magidson et al. (2015) discusses how the BATD approach was adapted and delivered by CHWs using ADAPT–ITT.

local interventions. The review surfaced more robust evidence for treatments like TF-CBT and NET, but these tend to focus on individual (versus group or community) impact and are clustered in certain countries.[96] Interventions deemed successful in Iraq, such as BATD and NET,[97] have not yet been replicated in other FCAS, nor in other (non-civilian) populations.

- **Timings and types of intervention.** The RoE surfaced little evidence on the appropriate foundation for, or sequencing of, trauma and conflict recovery interventions. It is yet to be evaluated how livelihood provision or trauma interventions should be sequenced.

- **Siloed approaches across disciplines on conflict and trauma.** Evidence on ACE[98] strongly suggests that the **cumulative effects of armed conflict violence will have severe long-term effects on an individual's physical health, mental health, and socio-economic opportunities**. While much work has been done to measure the economic impact of civil war, there is minimal recognition in the peacebuilding, conflict resolution, and civil war literatures of the mental health impact of surviving civil war.

### 3.2.4 Missing populations and gender biases

- **Extremely vulnerable populations are largely absent from trauma-focused interventions**. Only one study in Syria mentioned disabled participants,[99] and only one study specifically included widows.[100] We therefore know little about how trauma impacts populations that are particularly vulnerable, including the elderly, widows, the disabled, and those with pre-existing mental health issues or other psychobiological susceptibility to environmental stresses. **There is limited data on the protective and supportive role non-family groups play for trauma-exposed people in FCAS**. For example, within the literature reviewed, there is a noticeable preference for family as a central source of support. This is understandable but fails to consider that parenting can be affected by trauma, and that trauma (and violence) can be learnt and disseminated intergenerationally. This means that family/kin may not be able to provide the resources and support necessary.[101] For example, girls who have experienced female genital mutilation report that it is often conducted by their own mothers or guardians/relatives.[102] In addition, civilian communities run the risk of being idealised at the expense of other groups such as the military, religious/spiritual groups, or even gangs. These collectives may also provide resources, relationships, and support.

- **Knowledge is limited about the pathways by which women are socialised into becoming victims and perpetrators**. Evidence from other trauma contexts strongly suggests that long-term exposure to episodes of public violence can affect future levels of violence as both perpetrator and victim of domestic violence,[103] but little is known about these pathways and their differential effects in FCAS.

### 3.2.5 Missing populations: children and perpetrators of violence

Research is limited on the mental health and trauma of military and security personnel, adult ex-combatants, extremists, prisoners, and

96 High-quality studies that focus on CBT, CPT, NET, and CETA have been conducted in Iraq and DRC. See, for example, Bass et al. (2013), McMullen et al. (2017), Bolton et al. (2014), and Mahmooth et al. (2018).

97 Bolton et al., "A Randomized Controlled Trial".

98 K. Hughes et al., "The Effect of Multiple Adverse Childhood Experiences on Health", *Lancet Public Health* 2 no.8 (2017): e356–e366.

99 Ziveri et al., "The Impact of Psychosocial Support".

100 Jacob et al., "Dissemination of Psychotherapy".

101 H. Eltanamly et al., "Parenting in Times of War: A Meta-Analysis and Qualitative Synthesis of War Exposure, Parenting, and Child Adjustment", *Trauma, Violence, & Abuse* 22, no. 1 (2021): 147–60.

102 See for example, S. O'Neill and C. Pallitto, "The Consequences of Female Genital Mutilation on Psycho-Social Well-Being: A Systematic Review of Qualitative Research", *Qualitative Health Research* 31, no. 9 (2021): 1738–50.

103 I. Gutierrez and J. Gallegos, *The Effect of Civil Conflict on Domestic Violence: The Case of Peru*. RAND Corporation, 2016.

detainees in FCAS[104]. For example, only one study addressed the mental health of current or former military and security personnel (in Burundi).[105] Interventions were found to target predominantly civilian communities (particularly women and children), with only a few directed at ex-child (rather than adult) soldiers[106]. This suggests that there is a hierarchy of those who are seen as being 'deserving' of recovery. This 'hierarchy of victimhood'[107] is constructed around the notions of victimacy and civilianhood. It also speaks to the practical challenges of including these populations in trauma-focused interventions, given the constraints of access, funding, and policy preferences[108].

It is perhaps understandable that with finite resources, the donor community must selectively prioritise who gets to participate in trauma interventions. Most of the studies included in this review set the criteria for inclusion based on (a) PTSD scores, (b) the nature of victimhood, and (c) the civilian nature of their current identity.

Yet there is a danger that focusing only on those who are assumed to be victims or witnesses of traumatic violence neglects others who are critical to community recovery. Groups such as adult (male and female) ex-combatants, current serving members of state security forces, as well as prisoners, (former) extremists, non-state armed groups, militias, and gangs may continue to inflict violence at the individual, household, and community level in profound, though poorly understood, ways resulting from their own exposure to traumatic violence.

The binaries adopted by most of the studies produced reductive categorisations of combatant/civilian, victim/perpetrator, deserving/undeserving, male perpetrator/female victim. Those who commit violence during peacetime, within homes, and in society are also present within civilian communities. Dichotomies do not reflect the experiences of individuals during wartime or peacetime; identities are often multiple and fluid. People in FCAS simultaneously navigate multiple identities – code-switching between witness, perpetrator, and victim of violence – depending on circumstance and context. The idealisation of civilian communities that resonates throughout the existing literature obscures the fact that violence and trauma are transmitted inter-generationally, through family bonds and ties.

> **"...Research is limited on trauma interventions among military and security personnel..."**

This review concludes that interventions must allow for the fraught reality of violence and peace, and that any type of societal recovery must incorporate trauma interventions directed at all groups within conflict-affected communities but whose lived experiences of violence defy a simple categorisation.[109]

#### 3.2.5.1 Children

There is a lack of evidence and knowledge about effective psychosocial and therapeutic interventions for former child soldiers, especially those who have grown up under the control of extremist groups like the Islamic State of Iraq and ash-Sham (ISIS) and who may have had to participate in violence from a very young age. This is a concern because there may be a

104 This is often in contrast to the plethora of studies that look at veterans' mental health issues in high-income countries. However, one exception is Köbach et al. (2017).

105 C. Nandi et al., "Predictors of Posttraumatic Stress and Appetitive Aggression in Active Soldiers and Former Combatants", *European Journal of Psychotraumatology* 6, no. 1 (2015): 26553.

106 The following studies looked at former child soldiers: McMullen et al. (2013), Ertl et al. (2011), Borisova et al. (2013), Harris (2007), and Robjant et al. (2019).

107 J. Cook and G. Vale, "From Daesh to 'Diaspora' II: The Challenges Posed by Women and Minors After the Fall of the Caliphate," *CTC Sentinel* 12, no. 6 (2019): 30–46.

108 Nevertheless, the practical aspects of conducting research amongst perpetrators, terrorists, and detainees in FCAS need to be highlighted – an issue one of our anonymous reviewers pointed out. For example, the challenges in gaining ministry approval and ethical approval are important to consider when exploring the dearth of data on interventions targeting perpetrators.

109 As one of our anonymous reviewers pointed out, this is frequently an issue of donor and implementer preferences rather than researchers' bias.

whole generation of 'hidden' trauma-affected children at risk of violent extremism in camps and communities in Iraq and Syria.

The connection between trauma and radicalisation is complex and represents a nascent yet vitally important field of future inquiry. To date, the main focus has been on researching and exploring the behavioural and psychological impact of ACE. For example, a study of former white supremacists found that extremist onset did not begin with a single life event but was generated and then exacerbated by the cumulative impact of multiple occurrences of ACE.[110]

None of the studies in this review focused on children aged below eight. However, there are some important exceptions, such as the Injaz 2 study (conducted by Chemonics),[111] which integrates psychosocial support (PSS) in school educational settings for children affected by ISIS violence and the violent narratives propagated by ISIS.

One of the few studies that examined the psychological needs of former ISIS child soldiers in northern Iraq is Langer and Ahmad's report.[112] They employed a collaborative storytelling methodology as a participatory method of trauma processing, encouraging small groups of three to five children to develop a story about a fictional ISIS child soldier.

The story begins prior to the arrival of ISIS, follows the created character through his time in ISIS and into the present, with a brief projection to his possible future. The authors bleakly state that "[t]here are no specific concepts to work with former ISIS child soldiers that would allow meaningful processing; therefore, therapeutic and psychosocial concepts need to be developed in the region collaboratively with actors in the field, taking into account experiences from other contexts of child soldiers".[113]

#### 3.2.5.2 Participant characteristics: witnesses, victims, perpetrators?

This review set out to analyse interventions that focused on two broad categories of trauma-affected populations in conflict areas in MENA and Sub-Saharan Africa: those who witnessed violence or who were victims of violence, and those who perpetrated or participated in violence (whether forcibly or voluntarily). However, only one study looked at perpetrators of violence (adult, male Burundian soldiers), while four focused on ex-child soldiers. These five studies represent just over 5% of the studies reviewed. The vast majority (about 95%) focused on populations who displayed trauma symptoms and were victims of sexual and gender-based violence (SGBV) or torture, or who were described more generally as 'war-affected'.

Five reviewed studies examined interventions that were focused on adolescent former child soldiers. Borisova et al. included male and female child soldiers,[114] whilst Robjant et al.'s was the only study to assess the impact of FORNET on female ex-child soldiers.[115] The other studies employed group-based trauma-focused mechanisms (CBT[116] and NET/academic catch-up,[117] respectively), which were efficacious in reducing PTSD and psychosocial distress.

Borisova et al. and Harris addressed the mental health issues of former child soldiers in Sierra

110 S. Windisch et al., "Measuring the Extent and Nature of Adverse Childhood Experiences (ACE) among Former White Supremacists", *Terrorism and Political Violence* 34, no. 6 (2020): 1207–28.

111 Injaz 2, *Supporting Moderate Education in Syria*. Chemonics, 2022. https://chemonics.com/wp-content/uploads/2022/05/Injaz-II-Final-Report.pdf

112 P. Langer and A.-N. Ahmad, *Psychosocial Needs of Former ISIS Child Soldiers in Northern Iraq*. International Psychoanalytic University Berlin, 2019. https://www.mhinnovation.net/sites/default/files/downloads/innovation/reports/ISIS-Child-Soldiers-Project-Report-2019%5B1%5D.pdf

113 *Ibid.,* 26

114 I. Borisova, T. Betancourt, and J. Willett, "Efforts to Promote Reintegration and Rehabilitation of Traumatized Former Child Soldiers: Reintegration of Former Child Soldiers in Sierra Leone: The Role of Caregivers and Their Awareness of the Violence Adolescents Experienced During the War", *Journal of Aggression, Maltreatment and Trauma* 22, no. 8 (2013): 803–28.

115 Robjant et al., "The Treatment of Posttraumatic Stress".

116 J. McMullen et al., "Group Trauma-Focused Cognitive-Behavioural Therapy with Former Child Soldiers and Other War-Affected Boys in the DR Congo: A Randomised Controlled Trial", *Journal of Child Psychology and Psychiatry* 54, no. 11 (2013): 1231–41.

117 V. Ertl et al., "Community-Implemented Trauma Therapy for Former Child Soldiers in Northern Uganda: A Randomized Controlled Trial", *JAMA* 306, no. 5 (2011): 503–12.

Leone more holistically. Borisova et al. examined the role of caregivers' awareness of adolescent violence, and emphasised the importance of family and care in helping former child soldiers deal with war trauma and community reintegration. Harris assessed how dance/movement interventions promoted enhanced peer interaction, empathy, and community reconciliation amongst a small group of ex-RUF (Revolutionary United Front) child soldiers in Sierra Leone.[118] The study found that dance-based therapy, in which the participants created a public performance highlighting their dual roles as both victims and perpetrators in the war, advanced their reconciliation with, and acceptance by, the wider community.

Robjant et al.'s study of female former members of the March 23 Movement (known as M23, an armed group mostly active in DRC) contributes important nuances to the analysis of trauma interventions for former soldiers. The study is of relevance because the 93 women who participated in the intervention occupied dual roles of victim (they had been abducted and raped by M23 as young teenagers) and perpetrator (fighting in M23 and instigating violence within their households and wider communities on return).

Women and girls form a sizeable proportion of armed groups in conflict regions, yet research into the mental health of female combatants and female soldiers in FCAS is extremely limited compared to that of males, and treatments have rarely been rigorously investigated. In general, interventions and analysis addressing the mental health of the military (police and army) in FCAS settings is minimal, yet remains of critical importance if we are to better understand (i) what drives violent and peaceful behaviour, and (ii) what interventions are most effective in reducing trauma and the violent consequences of trauma amongst different populations in FCAS.

### 3.2.6 Why including perpetrators of violence matters

Appetitive aggression refers to an intrinsic sense of finding violence appealing and rewarding. It has been associated with the perpetration of violence during and after combat.[119] A study of Burundian soldiers found that appetitive aggression and PTSD symptoms were related to the perpetration of community violence at home following deployment.[120] Of relevance to policy and research into the drivers of peace and violence in FCAS is that an increased propensity for appetitive aggression has been connected to past ACEs and self-committed violence. Indeed, appetitive aggression is also linked to violence within the household (including corporal punishment of children). This suggests that, unless dealt with, household violence coheres with wider communal and societal violence to create cycles of multilevel violence that are difficult to eradicate.[121]

From the wider literature, we know that repeated exposure to traumatic stressors such as combat and violent conflict can result in chronic symptoms of PTSD, but this is not the only consequence. The literature on appetitive aggression suggests that exposure to and participation in violent conflict can, in some people, result in a prolonged 'lust for violence'. But questions remain as to why such patterns have been observed in some people and not others.

Weierstall et al.'s study on PTSD and appetitive aggression amongst former Colombian guerrillas and paramilitary forces found that appetitive aggression may be a survival response whilst in a violent environment and is associated with a reduced risk of combat-related traumatisation.[122]

118 Harris, "Pathways to Embodied Empathy".

119 T. Elbert, R. Weierstall, and M. Schauer, "Fascination Violence: On Mind and Brain of Man Hunters", *European Archives of Psychiatry and Clinical Neuroscience* 260, no. 2 (2010): 100–05.

120 C. Nandi et al., "Predicting Domestic and Community Violence by Soldiers Living in a Conflict Region", *Psychological Trauma: Theory, Research, Practice, and Policy* 9, no. 6 (2017): 663–71.

121 K. Robjant et al., "Trauma, Aggression, and Post Conflict Perpetration of Community Violence in Female Former Child Soldiers—A Study in Eastern DR Congo", *Frontiers in Psychiatry* 11 (2020): 533357.

122 R. Weierstall et al., "Relations among Appetitive Aggression, Post-Traumatic Stress and Motives for Demobilization: A Study in Former Colombian Combatants", *Conflict and Health* 7, no. 1 (2013): 1-10.

However, it may damage people's ability to develop peaceful pro-social behaviours. Another study suggests that how and why individuals disengage from armed groups shapes the extent to which they may experience PTSD or appetitive aggression. For example, guerrilla troops who demobilised as individuals because they were tired of fighting reported high levels of both appetitive aggression and trauma. In contrast, those who demobilised collectively showed higher levels of appetitive aggression than those who demobilised individually but lower levels of PTSD.[123] These findings, if replicated in Syria, South Sudan, and Iraq, have important implications for designing and implementing demobilisation and reintegration programmes, as well as for the kinds of therapeutic interventions that might help fighters adjust and contribute to (rather than undermine) peacebuilding endeavours. However, the extent to which violent behaviour is a psychological response, as opposed to a purely social, political, or economic one, is unclear.

Appetitive aggression is not the preserve of male soldiers or combatants alone. Exposure to violence can also result in females developing appetitive aggression.[124] Even in 'civilian' communities, there may be a large percentage of people with appetitive aggression, yet because it is found to protect against PTSD and enhances functioning, people suffering from this condition may be missed. According to the reviewed studies, this is particularly relevant in the context of FCAS for three reasons.

First, mental health interventions are focused quite narrowly on PTSD, rather than more broadly on violence and aggression. Second, norms of aggression and violence may make it difficult to distinguish appetitive aggression from wider norms, values, and behaviours. Furthermore, when appetitive aggression protects against PTSD symptoms, combatants and soldiers would be neither eligible nor motivated to engage in treatment for PTSD. The potentially widespread nature of appetitive aggression within different communities in FCAS indicates a need for community-based, inclusive therapies that not only address violent behaviour but also include components that strengthen peaceful, pro-social behaviour and inclusion.[125]

If practitioners exclude combatants, soldiers, prisoners, and extremists from interventions, and do not nuance their constructions of victims, perpetrators, and witnesses sufficiently, then programmes risk obscuring trauma symptoms that may shape violent and peaceful behaviour in profound ways. To date, much of the research on appetitive aggression has been conducted in Burundi, DRC, and South Africa amongst low-ranking soldiers and combatants. As such it remains unknown, for example, what form appetitive aggression may take in South Sudan or Iraq, or amongst political and military leaders, nor the implications it may have for violence and peace at the macro level.

Treating the PTSD symptoms of people who have participated in violence (for whatever reason) in low- and middle-income countries targets only one side of the problem. If root behavioural causes are not addressed first, then it is likely to hinder the long-term success of peacebuilding endeavours.

## Conclusion

This RoE on trauma recovery covers a wide repertoire of interventions, approaches, research designs, and countries. There is little agreement in terms of what constitutes 'best practice' when it comes to recovering from conflict-related trauma. Interventions to mitigate the negative effects of trauma need whole-of-government coordination at national and international level. However, measures of success or effectiveness are highly contested, context-specific, and individualised.[126]

123 R. Weierstall et al., "Appetitive Aggression and Adaptation to a Violent Environment among Youth Offenders", *Peace and Conflict: Journal of Peace Psychology* 19, no. 2 (2013): 138–49.

124 D. Meyer-Parlapanis et al., "Appetitive Aggression in Women: Comparing Male and Female War Combatants", *Frontiers in Psychology* 6 (2016): 1972.

125 Robjant et al., "The Treatment of Posttraumatic Stress".

126 We are grateful to one of our anonymous reviewers for elucidating this.

Nevertheless, we have identified a number of key findings that can inform work to reduce the negative impact of trauma on individuals and groups in FCAS. This section summarises the key findings and common elements that emerge from the RoE. It then provides some policy and programming recommendations.

# Key findings and implications

### Intervention effectiveness

- **Trauma-focused interventions like TRT, NET, and CPT/CBT were the most effective in reducing PTSD, anxiety, and depression** amongst civilian populations living in conflict-affected areas. TRT reduced disassociation, PTSD, and depression, whilst NET helped victims of torture in MENA. The few studies that focused on former fighters suggest that FORNET reduced mental health problems and aggressive traits linked to experiences of war.

- **Cash transfers alone were ineffective in reducing trauma symptoms or meeting household needs**. Livestock asset transfers, however, led to a decrease in participants' anxiety and depression, a reduction in IPV, and an increase in economic resources. Thus, interventions focusing on asset transfers rather than cash transfers may be more effective at alleviating a range of economic and behavioural challenges in FCAS. Put differently, livelihood provision and support are necessary but not sufficient to ameliorate trauma symptoms at the individual level and may be more effective at the community level. **Creating opportunities for 'flow' to occur in intervention participants is important**. Culturally embedded and arts-based therapies assist in recovery from trauma because they provide opportunities for social interaction and support. They also combine mind-body elements of therapeutic recovery and may work by facilitating 'flow', allowing those affected by trauma to have a much-needed break from intrusive thoughts and painful memories.

- Interventions that focus on **reducing appetitive aggression resulting from traumatic/violent exposure need to be integrated into policies and programmes**. Few studies measure or even consider the individual, household, and community impact of trauma-related aggression.

- **Non-trauma-focused interventions may also be effective**. For example, sociotherapy and sports-based activities encouraged new relationships to develop and supported old ones whilst also reducing trauma symptoms.

### Intervention delivery

- **More culturally relevant approaches to trauma reduction are needed** if interventions are to address the complex social dimensions of suffering following disruptive, traumatic episodes. It is important that interventions in FCAS be aimed primarily at nurturing and amplifying mechanisms for wider resilience, rather than just addressing aggregations of individual symptoms. A social ecology approach to trauma is lacking in many of the studies reviewed.

- **Local, community-based mental health workers can deliver mental health interventions effectively**, but only if they are given the latitude to integrate and adapt Western models and treatments of trauma to the needs of their communities. Western models are unlikely to be effective without cultural adaptation. The studies reviewed here indicate that CHWs can be trained to deliver modified versions of CBT, CETA,[133] CPT, and NET. A train-the-trainer model also proved effective. However, an analysis of how cultural adaptation works in practice is missing from the literature.

### Knowledge gaps

- **Behavioural outcomes of trauma interventions need to measure both peaceful and violent behaviour**. Currently, the causal connections between trauma and violence and trauma and peace have not been robustly explored in FCAS.

- **There is a lack of evidence on effective interventions to reduce trauma amongst**

**individuals and groups who have perpetrated violence**. These 'missing populations' include current and former members of state security forces and former members of non-state armed groups, as well as ex-ISIS members and their families.

- **Robust, high-quality studies can be conducted in FCAS**. There is a need to build on this evidence base and to replicate successful studies in different contexts and with different populations.

# Recommendations

There are a number of elements that can be included in intervention programmes to increase their outreach and effectiveness. These elements should be included at different stages of an intervention.

## Design stage

Populations included in programming should be expanded to include:

- adult males in parallel to women and children
- prisoners/detainees
- younger children (under 10).
- disabled individuals
- widows
- minority groups
- those who have committed acts of violence (in the household and the community, and 'professionally')

**Gather baseline data** on identified populations from multi-disciplinary perspectives:

- Include mental and physical health, exposure to/experience of violence at individual, household, and community levels.
- Identify existing norms that shape how populations understand and respond to violence and violence-related trauma, and that might require norm-change for interventions to be effective.

**Settings**

Expand settings to reach different communities/groups, not just in IDP/refugee camps or civilian communities. Include formal and informal educational institutions, hospitals and medical centres, schools, colleges and universities, training facilities, and detention centres and prisons.

**Timing**

Consider laying the foundations for later, more specific trauma-focused interventions with 'light' non-trauma-focused interventions (to avoid stigma and labelling trauma as something negative or unusual as opposed to a common/normal reaction) that create or enhance opportunities for local communities to develop social support mechanisms (e.g. through sport/dance/theatre/media and livelihood opportunities).

**Engagement**

- Ask potential beneficiaries what they need.
- Identify existing mechanisms, actors, institutions, and relationships that already assist in managing trauma, and social support that can be built on and engaged with.
- Engage local leaders – economic, educational, social, security, religious, and political – not just local 'peacebuilders', in the design process to ensure buy-in and adaptation at different levels and with different influencers. Reducing trauma requires engagement by actors and institutions that may not be traditionally included in the design and implementation of development/trauma-centred programmes.

Media campaigns and face-to-face dissemination can help people identify trauma symptoms and anti-social, trauma-induced violent behaviour. Media campaigns can also offer ways to deal with these issues. However, this needs to be led and created by trusted local actors who are

seen by the population as legitimate. Information campaigns need to be delivered by relevant actors and contain suitable information depending on the target population and context.

## Implementation stage

Regardless of the type of intervention, the following elements were found to be important in shaping the quality of interventions:

- **Create safe spaces** (for adults and for children). These might look different depending on the type of population. They could be in existing venues that are used regularly by individuals, such as medical centres or religious buildings.
- **Listen and validate**. Develop opportunities for participants to feel listened to and have their experiences validated.
- **Expand** target populations away from a narrow focus on victims to include those who perpetrate violence.
- **Focus on community and familial ties and relationships** within household/family networks, between parents and children, between spouses, and between different age groups (youth and elderly, for example).
- **Facilitate train the trainer activities with local actors.** Provide opportunities for them to own the intervention by developing, adapting, and integrating it with their own ways of 'doing and knowing'. This could be done through existing educational and religious institutions.
- **Integrate spiritual dimensions** into interventions by engaging relevant actors/institutions, such as faith-based mechanisms or individual and group prayer/worship.
- **Acknowledge the relational dynamics and importance of interventions explicitly.** Focus on using interventions as an opportunity for individuals to strengthen existing relationships and develop new ones to augment and provide alternatives to threadbare or more strained/limited ones.
- In individual/interpersonal therapy, **ensure that counsellors are local and have legitimacy**. It is critical to ensure age, gender, profession, and ethnicity are appropriate for a trusting, validating relationship to develop. Lay counsellors, with appropriate training and good supervision, can deliver psychotherapy where there are insufficient numbers of mental health professionals.

## Measuring outcomes

- **Expand measurement/outcomes** away from a narrow trauma focus (for trauma-focused interventions) and include multiple domains, especially regarding aggressive/violent and peaceful behaviour, and physical health.
- For non-trauma-focused interventions, like livelihood support and GBV programmes, **evaluate the impact** of programmes on trauma and behaviours (violence, aggression, and peace), as well as on mental and physical health.
- **Measure attitudes to violence and peace across intervention populations** and at the individual and community level.
- **Measure programme impact on attitudes to violence and peace** (at individual and community level) amongst different populations (civilians and combatants, for example).
- **Measure interventions' impact longitudinally** and beyond the immediate programme completion.

# Appendix

## Countries covered by the studies in this RoE

| | |
|---|---|
| Turkey | 6 |
| Rwanda | 6 |
| Uganda | 8 |
| Democratic Republic of the Congo | 12 |
| Sierra Leone | 5 |
| Burundi | 3 |
| Syria | 9 |
| South Africa | 2 |
| South Sudan | 4 |
| Guinea | 1 |
| Liberia | 1 |
| Libya | 1 |
| Iraq | 10 |
| Somalia | 1 |
| Jordan | 2 |
| Palestine | 2 |
| Lebanon | 2 |
| Multi-site (Jordan, Palestine, Egypt, Lebanon, Iraq, Tunisia, Iraq, Libya, Sudan, Syria) Viller Hansen | 1 |

## Search Terms for Systematic Database Searches

**COUNTRY**: South Sudan OR Iraq OR Syria

**INTERVENTION**: treatment* OR intervention* OR therapy OR psychotherapy OR counseling OR counselling OR training OR psychoeducation OR promotion OR prevention OR Program* OR “Home visiting” OR Support

**POPULATION**: Child* OR Adolescent* OR Preadolescent* OR Youth* OR “Young people” OR “Young person*” OR Infant* OR Family OR Families OR Kin OR Parent* OR “child soldier*” OR “child combatant*” OR “children associated with armed forces and armed groups” OR “CAAFAG” OR Refugee OR IDP OR soldier OR combatant OR police

**OUTCOME**: Behavior OR Behaviour OR “Mental Health” OR “Mental-Health” OR Psychosocial OR Psychological* OR resilience* OR “posttraumatic growth” OR “post-traumatic growth” OR “post traumatic growth” OR “Posttraumatic stress” OR “Post traumatic stress” OR “Posttraumatic stress” OR Trauma OR PTSD OR PTSS OR Depression OR “Depressive Disorder*” OR MDD OR Anxiety OR “Anxiety disorder*” OR Stress OR Distress OR Emotion* OR Suffering OR “Depressive symptom*” OR “anxiety symptom*” OR wellbeing OR “well being” OR well-being OR coping OR psychopathology OR “Quality of life” OR Suicide* OR “Mental Disorder*

## Quality assessment

Quality assessment was guided by the principles of research quality outlined in DFID's How to Note 2014.[127] The six criteria in this publication were employed by researchers for the Conflict Prevention Rapid Evidence Assessment commissioned by DFID in 2016.[128] The principles outlined in How to Note are flexible and applicable to both quantitative and qualitative research methods.

| Principles for quality assessment | Questions | Score<br><br>1 = major concerns<br>2 = some concerns<br>3 = no concerns<br>(Aggregate score for each study) |
|---|---|---|
| **Conceptual framing** | Does the study acknowledge existing research? Does the study pose a research question or outline a hypothesis? | |
| **Transparency** | Is it clear what the geography/context is in which the study was conducted? Does the study present or link to the raw data it analyses? Does the study declare sources of support/funding? How clear is the study about the quality (and limitations on quality) of the primary data? How clear is it about sampling decisions and site selection, etc.? | |
| **Appropriateness of method** | Does the study identify a research design and data-collection and analysis methods? Does the study demonstrate why the chosen design and method are well suited to the research question? | |
| **Validity** | To what extent is the study internally valid (valid in terms of where the research was done)? | |
| **Cultural/context sensitivity** | Does the study explicitly consider any context-specific cultural factors that may bias the analysis/findings? Is the study transparent in how it integrates or deals with culture-specific factors (values, norms, and practices)? | |
| **Cogency** | To what extent does the author consider the study's limitations and/or alternative interpretations of the analysis? Are the conclusions clearly based on the study's results (rather than on theory, assumptions, or policy priorities)? | |

127 DFID, *How to Note: Assessing the Strength of Evidence* (London: DFID, 2014). https://www.gov.uk/government/publications/how-to-note-assessing-the-strength-of-evidence

128 C. Cramer, J. Goodhand, and R. Morris, *Evidence Synthesis: What Interventions Have Been Effective in Preventing or Mitigating Armed Violence in Developing and Middle-Income Countries?* (London: DFID, 2016).

### Assessing the impact of interventions

The impact or effectiveness of interventions was assessed using the table below based on the criteria employed by Cramer, Goodhand, and Morris.

| Impact of intervention | |
|---|---|
| **Effective Intervention** | The intervention had a positive impact on mitigating symptoms of trauma that could be causally attributed to the intervention. |
| **Promising Intervention** | The intervention only had an impact on intermediate outcomes, or it had a positive impact on one outcome but not on others. |
| **Mixed Results** | Studies based on a variety of designs or methods that produced results found to have both effective and ineffective impacts. In other words, these studies would constitute mixed evidence of the impact of the overall intervention. |
| **Ineffective Intervention** | The intervention had no positive impact on mitigating trauma (and may even have had a harmful impact). |
| **Measure of Impact Inconclusive** | Attempts to examine the impact of an intervention concluded that there was insufficient evidence to make a judgement on impact. |

### Inclusion and exclusion criteria

1. Populations were civilian children, youth, and adults of both sexes living in an area affected by violent conflict, or combatants who had participated in violent conflict either as current or former members of state security forces (army or police) or as current or former members of a non-state violent/extremist group, violent non-state armed group, militia, violent criminal gang, or rebel group. This includes child soldiers, women associated with armed groups, prisoners/detainees, and IDPs. Studies were also included where the parents/kin and community members of youth or combatants participated in an intervention related to youth/combatant outcomes.

2. Treatment was a psychosocial intervention, including group, individual, self-help, family-based, or community-based interventions. It could involve specialised services, focused non-specialised services, and strengthening community and family support. We also included interventions that aimed to reduce the negative effects of trauma through the provision of basic needs, educational opportunities, and services and security (to incorporate broader peacebuilding initiatives such as media, education, and DDR/SSR, aswell as clinical and psychosocial therapies).

3. The treatment or intervention was conducted in Syria, South Sudan, or Iraq, OR in another conflict-affected country in SSA or MENA. Refugee populations from Syria, South Sudan, and Iraq who were living in neighbouring countries (i.e., Uganda, Jordan, Lebanon, and Turkey) were included.

4. The study design was a quantitative, qualitative, or mixed-methods outcome or programme evaluation. Quantitative included experimental, quasi-experimental, statistical analysis, and descriptive statistics. Qualitative included interviews/FGDs only, case study, and ethnography. Mixed methods included mixed methods and case studies. The study design definition is quite wide because few RCTs have been conducted in Syria, South Sudan, and Iraq.

5. Studies focused on different communities of practice: community/local interventions, external practitioners (NGOs, INGOs), specialist and non-specialist medical, and therapeutic practitioners.

**6.** Exclusion criteria:

- studies on conflict-affected populations from Syria, South Sudan, and Iraq conducted in HICs
- studies conducted and published before 2000
- studies on populations not affected by violent conflict
- non-intervention, treatment, or evidence-based studies of trauma (i.e. those that looked at other health-related outcomes, such as HIV, maternal health, etc.)
- studies on veterans from countries in the Organisation for Security and Cooperation in Europe (OSCE) or HICs who had been deployed to Iraq, Syria, or other areas in MENA or SSA.

## Glossary of interventions

### Trauma-focused interventions

**Trauma-focused cognitive behavioural therapy (TF-CBT)** is a group therapy method recommended for children and young people with PTSD. It comprises the following modules: (a) psychoeducation, (b) stress management/relaxation techniques, (c) affect expression and modulation, (d) cognitive coping, (e) creating a trauma narrative, (f) cognitive processing, and (g) future hopes.[129]

**Teaching recovery techniques (TRT)** is a trauma-specific program based on CBT that focuses on normalizing the trauma response, teaching strategies to cope with intrusive memories, hyper-arousal, and avoidance symptoms of PTSD, as well as loss. TRT was originally developed for adolescents who experienced disaster situations, such as earthquakes and war trauma. Content includes: (i) case studies as exemplars for psychoeducation on traumatic events, normalising resultant symptoms, and stimulating the sharing of traumatic events; (ii) relaxation techniques and positive cognitions to help with emotional dysregulation; (iii) brief exposure to trauma reminders; and (iv) systematic desensitisation of anxiety and anger hierarchies for avoidance.[130]

**Narrative exposure therapy (NET)** aims to transform the generally fragmented reports of traumatic events into a coherent narrative. The treatment helps individuals, couples, or families reinterpret and rewrite their life events into true but more life-enhancing stories.[131] Exposure to the traumatic stress experience i does not end until the related arousal presented and reported by the client shows a significant diminution. The narrative is driven forward in a supportive manner by a counsellor to counter avoidance and to recover the full implicit information of the traumatic experience.[132]

**Narrative exposure therapy for forensic offender rehabilitation (FORNET)** is based on NET but is expanded to consider the client as both victim of trauma and perpetrator of aggressive acts. FORNET therefore targets symptoms of post-traumatic stress as well as tendencies to violent behaviour. Both traumatic experiences and perpetrated violence are addressed through narrative exposure using different therapeutic approaches including CBT, testimony therapy, interpersonal therapy, and client-centred therapy.[133]

129 McMullen et al, “Group Trauma-Focused CBT”.
130 Barron et al., “Pilot Study”.
131 American Psychological Association, https://www.apa.org/ptsd-guideline/treatments/narrative-exposure-therapy
132 M. Schauer, F. Neuner, and T. Elbert, *Narrative Exposure Therapy* (Hogrefe Publishing, 2011), 481–89.
133 Köbach et al., “Psychotherapeutic Intervention”.

**Behavioural activation treatment for depression (BATD**) is a succinct version of CBT that focuses on behaviour activation skills. It aims to understand the linkages between behaviours, thoughts, and emotions. Developed for treating depression, it can be utilised as a treatment on its own or alongside other CBT interventions like cognitive restructuring.

**Cognitive processing therapy (CPT)** emphasizes cognitive strategies to help people alter erroneous or unhelpful thinking that has emerged because of a traumatic event. CPT can be delivered both individually and in structured group sessions. Practitioners may work with clients on false beliefs that the world is no longer safe, for example, or that they are incompetent because they allowed the traumatic event to happen to them. The treatment generally entails 12 sessions that start with psychoeducation regarding PTSD, thoughts, and emotions before beginning more formal processing of the trauma(s) through guided questioning. CPT was originally developed with a written trauma account as an important component of the treatment, but it is sometimes delivered without it and with more emphasis placed on cognitive techniques.[134]

**Cognitive behavioural therapy (CBT)** is a talking therapy that can help people manage their problems by changing the way they think.[135]

**Common elements treatment approach (CETA)** was developed for lay counsellors in low- and middle-income countries (LMICs) and focuses on three mental health problems common in LMICs: depression, posttraumatic stress, and anxiety. It combines several evidence-based treatments (e.g. CBT for depression symptoms, gradual imaginal exposure for post-traumatic stress symptoms, and anxiety management strategies) into a modular approach that can be adapted to treat a range of difficulties. It is problem-focused rather than diagnosis-focused; the selection, order, and dosing of modules are tailored to each individual based on their presenting difficulties.[136]

### Psychosocial interventions

**Psychosocial** refers to “the dynamic relationship between the psychological and social dimension of a person, where the one influences the other”.[137]

**Psychosocial education** refers to psychosocial support interventions in schools and other educational settings that focus on the “processes and actions that promote the holistic wellbeing of people in their social world. It includes support provided by family and friends.”[138]

**Group interpersonal therapy** is a treatment of psychological problems in which two or more participants interact with each other on both an emotional and a cognitive level in the presence of one or more psychotherapists who serve as catalysts, facilitators, or interpreters. The approaches vary, but in general they aim to provide an environment in which problems and concerns can be shared in an atmosphere of mutual respect and understanding. Group therapy seeks to enhance self-respect, deepen self-understanding, and improve interpersonal relationships.[139]

**Stress reduction therapy (SRT)**, generally referred to as mindfulness-based SRT, is an eight-week group therapy programme focused on mindfulness, meditation, and yoga.

134 American Psychological Association, https://www.apa.org/ptsd-guideline/treatments/cognitive-processing-therapy
135 American Psychological Association, https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral
136 Murray et al., 2018.
137 IFRC Reference Centre for Psychosocial Support, https://pscentre.org
138 Interagency Network for Education in Emergencies, https://inee.org/collections/psychosocial-support-and-social-and-emotional-learning
139 American Psychological Association, https://dictionary.apa.org/group-therapy

### Alternative and culturally informed trauma-focused interventions

**Music/arts/theatre therapies** combine interdisciplinary approaches that explore the mind-body connection. The process of making art is seen as healing – an experience that provides the opportunity to express oneself imaginatively, authentically, and spontaneously. Over time, this process can lead to personal fulfilment, emotional reparation, and transformation.[140]

**Movement-based therapy** refers to a therapeutic technique in which individuals use rhythmic exercises and bodily movements to achieve greater body awareness and social interaction, and thus enhance their psychological and physical functioning.[141]

### Community-centred interventions

**Sociotherapy** refers to any supportive therapeutic approach that emphasizes socio-environmental and interpersonal factors in an individual's adjustment to his or her surroundings. It may be used with several other therapeutic approaches, such as family counselling, vocational retraining, and therapy aimed at assisting an individual's readjustment to community life following hospitalization for severe mental illness.[142]

**Cash transfers** are direct payments made to individuals, households, or groups with the aim of alleviating poverty. Originally a poverty alleviation strategy, it is also utilised in conflict and humanitarian contexts. A cash transfer can take the form of unconditional cash transfer, conditional cash transfer, labelled cash transfer, or livestock transfer.

**Child-friendly spaces (CFS)** were developed for humanitarian or conflict contexts and aim to provide "a temporary, safe environment in which children may establish some degree of normalcy supportive of their well-being in situations of extreme adversity".[143]

140 American Psychological Association, https://dictionary.apa.org/music-therapy, https://dictionary.apa.org/art-therapy

141 American Psychological Association, https://dictionary.apa.org/movement-therapy

142 American Psychological Association, https://dictionary.apa.org/sociotherapy

143 S. Hermosilla et al., "Child Friendly Spaces Impact Across Five Humanitarian Settings: A Meta-Analysis", *BMC Public Health* 19, no. 1 (2019): 1–11.

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