The transmission of violence in families living in a post-conflict context: An intergenerational study of the relationship between traumatic war exposure, family violence and psychopathology in northern Uganda

Zusammenfassung und Schriften der kumulativen Dissertation

zur Erlangung des Grades eines Doktors der Naturwissenschaften (Dr. rer. Nat.)

vorgelegt von

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Bielefeld, Februar 2015

Hiermit versichere ich, dass ich die vorliegende Synopse selbstständig sowie die für den Kumulus vorliegenden Schriften als Erstautorin verfasst habe. Damit trage ich die inhaltliche und methodische Verantwortung für die angeführten Schriften. Die Arbeit hat in der gegenwärtigen oder in einer anderen Fassung keiner anderen Fakultät oder Universität vorgelegen.

Bielefeld, 09.02.15

Regina Saile

Danksagung

Mein allerherzlichster Dank gilt

Allen Teilnehmenden der Studie, die sich die Zeit genommen haben, um über ihre Erfahrungen zu sprechen und damit diese Studie möglich gemacht haben. Ich möchte auch den Gemeindemitgliedern danken, die sich über die Studie hinaus für betroffene Menschen und deren Familien eingesetzt haben.

Claudia Catani, die mich an das Thema herangeführt hat, mir viel Vertrauen bei der Durchführung der Arbeit geschenkt hat, mich gut betreut hat, und die mir die Zeit gegeben hat, die ich brauchte.

Frank Neuner, der mir die Chance für diese Arbeit gegeben hat, mir viele Freiheiten zugestanden und mich gleichzeitig unterstützt hat.

Verena Ertl, in der ich eine Mentorin und Freundin gefunden habe, die ich niemals missen möchte.

Linda-Marleen Hinterding und **Julia Möllerherm**, die mich im Feld unterstützt haben, und die mit ihrem Einsatz und Durchhaltevermögen einen großen Beitrag zur Durchführung der Studie geleistet haben. Ich danke auch **Anett Pfeiffer** für ihren Rat und ihre Unterstützung.

Stephen Abola, Laura Achan, Doris Adong, Ajok Harriet Atimango, Awor Tina, Joyce Laloyo, Joseph Kizito, Richard Nyeko, Julius-Peter Oketayot, Julius Ongom, Onying George William für ihre unermüdliche Mitarbeit, ihr Engagement, ihre Empathie im Umgang mit den Studienteilnehmenden, ihre Professionalität, ihre wertvollen Ratschläge und für die außerordentlich bereichernde Zusammenarbeit.

Katy Robjant, die mich vor groben sprachlichen Ausrutschern bewahrt und die Manuskripte Korrektur gelesen hat. Danken möchte ich auch **Verena Ertl** und **Julia Möllerherm** fürs Korrekturlesen.

Meinen FreundInnen und meiner Familie, die mich mit viel Verständnis und Geduld begleitet haben, die viel zurückstecken mussten und doch immer für mich da waren.

Meinen Eltern, die immer alles gegeben haben, damit ich meinen Weg gehen kann, für ihre bedingungslose Liebe und Unterstützung.

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Published 2013 in *Social Science and Medicine, 86*, 17-25

1.1.2 Does war contribute to family violence against children? Findings from a two-generational multi-informant study in northern Uganda

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1.1.3 Children of the post-war years: A two-generational multi-level risk assessment of child psychopathology in northern Uganda

Authors: Regina Saile[1,2], Verena Ertl[1,2], Frank Neuner[1,2], Claudia Catani[1,2]
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1.2 Author contributions

1.2.1 Author contributions to the manuscripts

I was involved in the definition of the study concept and design, and in the funding process (e.g. accounting, writing reports). I carried the responsibility for the scientific methods together with my supervisors and monitored the compliance with these on site. I guided the translation and adaptation procedures of the study instruments. Together with my colleagues I conducted trainings on the study instrument and procedure. Under the supervision of my colleagues I developed a brief intervention for families affected by violence and trained the local team to carry out follow-ups and brief interventions. I continuously supervised the local team in the implementation of the study and the brief intervention on site, monitored data collection and entry, and provided supervision on site. I handled the day-to-day study administration and logistics. I managed and analysed the data, interpreted it and drafted the manuscript as first author.

1.2.2 Confirmation of first authorships and contributions

We, the co-authors of the specified manuscripts confirm that Regina Saile contributed to the research underlying the articles as stated above and drafted the manuscripts as first author.

PD Dr. Claudia Catani

Dr. Verena Ertl

Prof. Dr. Frank Neuner

2 Introduction to the common context of this research

2.1 Violence on a worldwide scale

2.1.1 A typology of violence

Violence imposes an immeasurable burden on individuals, families, communities and societies in all parts of the world and inflicts suffering on people indiscriminate of their nationality, ethnicity, age or gender (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Although violence is omnipresent, its multifaceted and dynamic nature makes it appear intangible as well as impregnable. In an attempt to organize this complex phenomenon the World Report on Violence and Health (Krug et al., 2002) introduced a typology of violence that differentiates three types of violence based on characteristics of the perpetrator-victim relationship: On an intra-individual level self-harm constitutes "self-directed violence"; in the context of interpersonal relationships violence perpetrated by another individual or a small group of individuals to which a person belongs is subsumed under the notion of "interpersonal violence"; and "collective" or organized violence describes societal or communal-level violence against an individual that is inflicted by a member representing a larger group such as a state, a political group, a militia, or a terrorist organization for example. Each type is subdivided into different subtypes of violence including physical, sexual and psychological violence as well as deprivation and neglect.

2.1.2 Rates and correlates of collective and interpersonal violence in different regions of the world: A brief overview

Despite its ubiquity, the chance of falling victim to violence is not equally distributed around the world. Collective and interpersonal violence, albeit interrelated, represent distinguishable forms of violence (Galtung, 1969). Both types of violence are overrepresented in the African regions compared to other regions of the world (Krug et al., 2002). Mortality data are the most available and most systematic source of information to measure violent outcomes. However, this type of data fails to capture the full scope of the problem because non-fatal outcomes are far more common than fatal outcomes (Krug et al., 2002). Studies on the prevalence of non-fatal interpersonal violence are more differentiated and more difficult to compare because they usually target certain population groups (e.g. women vs. men vs.

children) and certain victim-perpetrator-relationships (e.g. stranger vs. family member). Because of the great diversity of the literature the following paragraphs are restricted to aspects most relevant to the present study and aim for giving a brief overview of the nature and the scope of the problem. We narrowed our focus down to collective violence in the community context and interpersonal violence that occurs in the family and in the school context. Within the family context we regarded studies that address violence against women by an intimate partner and studies investigating violence against children by caregivers.

Collective violence in the community context

In 2010 the Heidelberg Institute for international conflict research counted 28 ongoing highly-violent conflicts including wars and severe crises worldwide (Heidelberg Institute for International Conflict Research, 2010). In a global comparison the loss of human lives due to war-related violence varied largely between regions with less than 1 per 100.000 in high-income countries and 6 per 100.000 in low-income and middle-income countries. In the African regions only low- and middle-income countries were represented. There, the estimated mortality caused by war-related injury was 32 per 100.000. In the African regions war ranked among the leading causes of death and disability (rank 11) (Krug et al., 2002).

In contemporary wars civilians have become deliberate targets in the quest for power (Kaldor, 1999). Men, women and children living in conflict settings report high rates of exposure to severe atrocities (e.g. Ertl, Pfeiffer, Schauer, Elbert, & Neuner, 2014; Vinck, Pham, Stover, & Weinstein, 2007). Although the atrocities committed by opposing parties may appear arbitrary at first glance, they constitute a systematic and deliberate strategy to gain control by destroying social bonds within the community and the family. As a consequence cultural meaning systems and frames of reference disintegrate (Mekki-Berrada, Rousseau, & Bertot, 2001). It may partly be due to this profound deconstruction of basic social entities and meaning systems that contemporary wars usually take the form of protracted intrastate social conflicts that produce mental and social states conducive to outlasting violence even when overt hostilities have ceased (Azar, Jureidini, Mclaurin, Azar, & Jureidini, 1978; Themner & Wallensteen, 2011).

In short, contemporary wars disrupt community and family functioning through the loss of lives, through the destruction of social bonds and through their derogatory effect on people's representations of non-violent means of achieving peace (Vinck et al., 2007).

Interpersonal violence in the family context

In the year 2000 the World Health Organization (WHO) estimated fatal interpersonal violence in the form of homicide to be as high as 8.8 per 100.000 population worldwide with rates of more than 20 per 100.000 population in the African regions. In the European and Western Pacific regions suicide accounted for the majority of violent deaths whereas in the African regions homicide rates were almost three times larger than suicide rates. In the African regions interpersonal violence constituted one of the leading causes of death (rank 14) and disability (rank 15) and was ranked higher than in any other region in the world even when compared exclusively to low- and middle income countries (rank 21) (Krug et al., 2002). The above figures do not differentiate between interpersonal violence in the community context and interpersonal violence in the family context. However, the high homicide rates of young children under the age of 5 (17 per 100.000 for boys and 13 per 100.000 for girls) in the African regions support the assumption that much interpersonal violence against children occurs within the family context (Acierno, Resnick, & Kilpatrick, 1997). A South African study found that about half of the female homicide victims died of intimate partner violence (IPV). The mortality rate from intimate partner violence was 8.8 per 100.000 women in this study (Abrahams et al., 2009). Although men also frequently experience violence from their partners (Ehrensaft et al., 2003; Zacarias, Macassa, & Soares, 2012) women are on average subject to more severe forms of abuse and are more likely to suffer serious injury or death as a consequence of partner violence (Acierno et al., 1997; Johnson, 2005; Kessler, Molnar, Feurer, & Appelbaum, 2001). The following paragraphs concentrate on a brief discussion what is commonly subsumed under the notion of non-fatal partner violence against women and family violence against children and intend to give an idea about the scope of the problem.

Partner violence against women

The majority of victimization experiences encountered by women in high-income countries seem to stem from intimate partner violence (Acierno et al., 1997; Tjaden & Thoennes, 2000). Most studies to date have defined partner violence as any violent act that occurred between partners regardless whether injuries occurred and irrespective of the legality of the behaviour (Straus, 2007). Beyond this categorical definition several authors stressed the dimensional nature of partner violence whereby more severe forms of abuse are more complex and include more different types of abusive behaviours and/or more severe acts of violence (Hegarty, 2007; Johnson & Ferraro, 2000; Johnson, 1995). Studies that investigated

intimate partner violence (IPV) usually included acts of physical, sexual and emotional violence by a current or former intimate partner. In addition, partner violence has been viewed as excessive controlling or threatening behaviours, such as constraining a partner's mobility or their access to friends and relatives (Johnson, 1995; Krug et al., 2002). The WHO multi-country study found a global lifetime prevalence of physical and/or sexual partner violence experienced by ever-partnered women of 30%, with prevalence rates ranging between 15% and 71% in different countries (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). Women in the African regions and particularly in the sub-Saharan African regions (central 66%, eastern 39%, western 42%) reported the highest rates of physical and/or sexual intimate partner violence victimization worldwide (World Health Organization, 2013). Within these regions, conflict-affected populations seem to experience even higher rates of physical and/or sexual intimate partner violence against women compared to regions unaffected by war (Uganda Bureau of Statistics, 2006).

Family violence against children

Although the United Nations Convention on the Rights of the Child calls on states to protect children from all forms of physical and mental violence, it is normative in virtually all countries of the world that caregivers inflict pain on children in an attempt to correct their behaviour (Krug et al., 2002; Straus, 2010). Culturally influenced attitudes towards physical punishment appear to increase parents' proneness to use violence against their children (Akmatov, 2011) but they do not seem to prevent children from perceiving these practices as hurtful and harmful (Lansford et al., 2005; Naker, 2005). Studies investigating the prevalence of child abuse usually target psychological aggression, as well as mild, moderate and severe physical abuse of children (e.g. Akmatov, 2011; Straus, Hamby, Finkelhor, Moore, & Runyan, 1998). This operationalization is consistent with the notion that aggressive parenting practices and more severe forms of abuse may be part of the same construct rather than representing qualitatively different types of interpersonal behaviour (Belsky, 1993; Gonzalez, Durrant, Chabot, Trocmé, & Brown, 2008; Straus, 2010).

As violence against children often involves the attempt to discipline children, it is not surprising that the main perpetrators of violence against children seem to be close relatives such as mothers, stepmothers, fathers, older siblings as well as teachers. Women appear to resort more often to physical punishment than men (African Child Policy Forum (ACPF), 2011; Catani, Schauer, & Neuner, 2008; Krug et al., 2002; Straus, Hamby, Finkelhor, Moore, & Runyan, 1998). Women in the African regions reported to use more physical violence

against their children compared to other countries in the world. This difference was markedly pronounced regarding severe physical abuse of children (43% median past-month prevalence in African countries versus 9% median past-month prevalence in other countries) (Akmatov, 2011).

The assessment of childhood maltreatment victimization is commonly based on retrospective self-reports of adult respondents. In a worldwide survey, the World Health Organization Mental Health Initiative examined a sample of 51.945 adults from nine high-income countries, six high-middle income countries and seven low/lower-middle income countries. Results showed that 5% to 11% of respondents experienced physical abuse as a child and 4% to 8% told of family violence in their childhoods (Kessler et al., 2010). In a German representative sample of 2.500 adults prevalence rates of emotional, physical and sexual abuse in childhood were 10%, 12% and 6%, respectively (Iffland, Brähler, Neuner, Häuser, & Glaesmer, 2013). When regarding studies that rely on adolescents' self-reports of maltreatment during childhood, high rates of physical maltreatment are confirmed: For example, a representative study of adolescents (N = 16.190) in nine major cities in Germany found that 10% had been maltreated during childhood (i.e. having been beaten up, punched with a fist, kicked, choked or injured with a weapon) and another 17% had experienced severe physical punishment (i.e. having been hit with an object or a higher frequency of having been thrown at, having been grabbed or pushed, or having been slapped) (Pfeiffer, Wetzels, & Enzmann, 1999). In low-income and conflict-affected settings severe to very severe acts of violence committed against children appear to be even higher. For example, a study that assessed 1.185 Palestinian adolescents revealed relatively high rates of very severe physical abuse such as being continuously attacked with a stick, club, or harmful object by mothers (30%) and fathers (20%) or attacks with lethal weapons by mothers (6%) or fathers (5%) (Haj-Yahia & Abdo-Kaloti, 2003). A retrospective study in 6 different African countries (Burkina Faso, Cameroon, Democratic Republic of Congo, Nigeria and Senegal) that was based on a sample of more than 3.000 young women aged 20 to 24 years showed that severe forms of physical violence (e.g. choking or burning 71% to 80%), psychological violence (e.g. wished not born or dead 11% to 30%; threatened with abandonment 11% to 36%) and sexual violence (e.g. being touched or fondled in the private parts 24% to 52%; rape 17% to 54%) were frequently experienced by girls under the age of 18 years (African Child Policy Forum (ACPF), 2011). Self-reports from a mixed sample of 777 Ugandan children and adolescents suggested that psychological abuse, physical abuse and sexual abuse were also frequently encountered by children in Uganda. Almost all respondents indicated to have

experienced some type of physical violence (98%) and/or psychological abuse (98%). Approximately every fifth child had been exposed to severe types of violence such as being burned on purpose. Twenty percent of girls and 13% of boys reported forced sexual intercourse (Naker, 2005). Evidence of severe physical violence was also found in other post-conflict countries such as Afghanistan (Catani et al., 2009) and Sri Lanka (Catani, Jacob, Schauer, Kohila, & Neuner, 2008). In these studies 11% of children in the Afghan sample and 18% of children in the Sri Lankan sample suffered injuries due to family violence. Nine percent of the children in Afghanistan and 10% of the children in Sri Lanka required medical care because of the injuries that were caused by family violence. Regarding these findings it becomes evident that the problem of family violence against children is a major public health concern particularly in African countries and those countries recently affected by armed conflict (Pinheiro, 2006).

Violence against children in the school context

Besides the family and the wider community, the school context may play a significant role in children's development. Despite legal bans on corporal punishment of children at school in many countries, the use of physical violence by teachers and class prefects to "tame" children is widespread (Pinheiro, 2006). In African countries such as Tanzania, Burkina Faso, Cameroon, Democratic Republic of Congo, Nigeria, Senegal, Ethiopia and Uganda children report frequent exposure to physical, psychological and also sexual violence at school (African Child Policy Forum (ACPF), 2011; Hecker, Hermenau, Isele, & Elbert, 2013; Naker, 2005). For example, in Uganda 60% of school children indicated that they were routinely beaten at school, although teachers asserted that they would keep to the "official policy" that forbid corporal punishment at school (Naker, 2005).

Peer victimization constitutes another form of interpersonal violence that often occurs in the school context. Children who display more externalizing behaviour symptoms are more likely to be rejected by peers (Kim & Cicchetti, 2010) and may be at an increased risk of being victimized. Peer victimization represents one of the most frequent victimization experiences among children in the western world (Finkelhor, Ormrod, Turner, & Hamby, 2005). In African societies peers have also been identified among the major perpetrators of psychological, physical and sexual violence (African Child Policy Forum (ACPF), 2011).

2.2 The impact of violence on individual mental and physical health

Exposure to organized violence in the context of war has been linked to a variety of mental health disorders in children (e.g. Catani et al., 2010; Olema, Catani, Ertl, Saile, & Neuner, 2013; Panter-Brick, Eggerman, Gonzalez, & Safdar, 2009) as well as adults (e.g. De Jong, Komproe, & van Ommeren, 2003). Posttraumatic stress disorder (PTSD) and major depression are two of the most widely identified psychological disorders following war trauma (e.g. De Jong et al., 2001; Karunakara et al., 2004; Thapa & Hauff, 2005; Johnson et al., 2008; Steel et al., 2009). Other mental health outcomes in the aftermath of organized violence include anxiety problems (Cardozo et al., 2004), somatoform symptoms (De Jong et al., 2003), alcohol abuse (Roberts et al., 2011) and suicidal ideation (Ovuga, Boardman, & Wassermann, 2005).

Intimate partner violence as one of the most prevalent forms of interpersonal violence exerts a devastating effect on men's and women's mental health, particularly with respect to PTSD, depression and substance abuse (Campbell, 2002; Coker et al., 2002; World Health Organization, 2013). In addition, in sub-Saharan Africa women who suffer from intimate partner violence are at an increased risk to be infected with HIV/AIDS (World Health Organization, 2013; Zablotska et al., 2009)

On a worldwide scale, findings from the World Mental Health surveys show that in the long-term childhood maltreatment (i.e. physical and/or sexual abuse and neglect) and family adversity (i.e. parental death, parental divorce, other separation from parents, parental mental illness, substance misuse, criminality, family violence, family economic adversity) account for almost one third of mental disorders (Kessler et al., 2010). Another major study with more than 8.000 adult subjects, the Adverse Childhood Experiences (ACE) study, revealed that adverse outcomes in terms of mental health (Edwards, Holden, Felitti, & Anda, 2003) and in terms of health risk behaviours and impairment in physical health (Felitti, Vincent, & Anda, 1998) increased with the severity childhood maltreatment (i.e. psychological, physical and/or sexual abuse) and family adversity (i.e. parental substance abuse, mental illness, inter-partner violence, criminality). Among adverse mental health outcomes of childhood maltreatment in adults, PTSD, depression, suicidality, and alcohol problems show the most consistent and distinct relationship with childhood victimization (Gilbert et al., 2009). The negative effect of childhood maltreatment on adult physical health was confirmed in a 30-year longitudinal study demonstrating that childhood maltreatment increased the risk for adult diabetes, lung disease, malnutrition and poor vision (Spatz

Widom, Czaja, Bentley, & Johnson, 2012).

Regarding children, the experience of childhood maltreatment and family adversity constitutes one of the most potent risk factors of a variety of emotional, cognitive, behavioural and attachment-related disturbances in childhood including PTSD, depression, anxiety, externalizing and internalizing behaviour problems, deficits in emotion regulation, distorted social information processing, impaired social functioning, insecure, disorganized attachment patterns to name but a few (e.g. Cicchetti & Toth, 2005; Cullerton-Sen, Cassidy, Murray-Close, Cicchetti, & Rogosch, 2012; Kim & Cicchetti, 2010; Manly, Kim, Rogosch, & Hope, 2001; Rogosch & Cicchetti, 2005; Toth & Cicchetti, 1996; Valentino, Toth, & Cicchetti, 2009). In particular, moderate to strong associations between child maltreatment and externalizing behaviour problems have been determined in children and adolescents (Gilbert et al., 2009). Witnessing inter-parental violence as well as experiencing harsh physical discipline predicted adverse mental health outcomes in children over time (Maikovich, Jaffee, Odgers, & Gallop, 2008; Margolin, Vickerman, Oliver, & Gordis, 2010). Witnessing inter-parental violence was more strongly associated with higher internalizing problems whereas harsh physical discipline predicted child externalizing behaviour problems. Thus, even when children are not directly victimized but experience violence in their family environment as witnesses, they are at an increased risk of developing psychopathological symptoms. In addition, children experienced higher symptoms and a higher co-morbidity of negative outcomes when they were exposed to violence from multiple domains including community violence, marital violence in the family and harsh physical discipline (Margolin et al., 2010).

Institutional violence including violence at school, particularly at an early age, represents another victimization experience that can have severe consequences for children's healthy psychological development (Hermenau, Hecker, Elbert, & Ruf-leuschner, 2014) and even more so when it combines with violence in the home (Hecker et al., 2013). Peer victimization that often occurs in the school context seems to execute an additional adverse effect on children's mental health. One study found that it was the only type of victimization experience that independently predicts anxiety, depression as well as aggression when multiple co-occuring victimization experiences are controlled for (Finkelhor, Ormrod, & Turner, 2007).

In summary, exposure to violence in multiple domains poses a major risk to individual mental and physical health. Consequently violence prevention becomes an important public health concern. In order to effectively prevent violence it is necessary to better understand the mechanisms that underlie the occurrence and continuation of violence.

2.3 The transmission of violence

2.3.1 The intergenerational transmission of violence

Among the multitude of risk factors that facilitate the occurrence of violence, exposure to violence itself is one of the most influential contributors. That is, previous exposure to violence renders an individual more vulnerable to experience and perpetrate further violence. The original research that was ignited by the "cycle of violence" hypothesis (Spatz Widom, 1989b) proved that persons who were maltreated as children were more prone to engage in delinquent behaviour and violent crime as adults (Spatz Widom, 1989a). This inter-generational transmission of violence has also been asserted with respect to child abuse perpetration: Parents who were maltreated as children are more likely to use violence against their own children, although the relationship appears to be moderate and varied in strength across studies (Berlin, Appleyard, & Dodge, 2011; Thornberry, Knight, & Lovegrove, 2012).

Childhood family violence and adversity also predispose victims for the experience of further trauma that is mostly interpersonal in nature (Dong et al., 2004; Spatz Widom, Czaja, & Dutton, 2008). Women with a history of childhood maltreatment are at an increased risk to be affected by partner violence in their adult intimate relationships (Abramsky et al., 2011; Ehrensaft et al., 2003). Inter-partner violence in turn frequently co-occurs with family violence against children (Appel & Holden, 1998) and it appears to contribute to women's child abuse potential (Banyard, Williams, & Siegel, 2003; Cohen et al., 2008). Thus, in the intra-familial transmission of violence re-victimization processes and the risk of perpetration seem to be closely intertwined.

Although the phenomenon of re-victimization has frequently been researched among female samples, it seems neither bound to gender (Spatz Widom et al., 2008) nor does it apply exclusively to the family context. For example, maltreated children are at an increased risk of being rejected and re-victimized by peers in the school context (Rogosch, Cicchetti, & Hope, 1994; Shields & Cicchetti, 2001). Male British soldiers who had experienced high levels of family adversity during childhood reported more traumatic war exposure during deployment (Iversen et al., 2007).

Overall, falling victim to violence in the family during childhood and experiencing high levels of childhood adversity appear to increase a person's vulnerability for subsequent victimization experiences in various environments.

2.3.2 The transmission of war to family violence

Researchers working in the context of complex emergencies where civil conflict and war precipitated high levels of violence in the community have contended that war-related violence constitutes an important contributing factor to violent interactions within the family (Catani, 2010; Clark et al., 2010; Straus, 2010). In particular, research to date has focused on violence against women and children in war-affected families. The WHO multi-country study provides indirect support for the hypothesized relationship between war-related violence and partner violence experienced by women as prevalence rates of ongoing partner violence appear highest in countries that have recently been affected by civil conflict (Stewart & Brown, 2010). Past-year prevalence rates of physical and sexual partner violence experienced by women were as high as 54% in Ethiopia (Garcia-Moreno et al., 2006) and 56% in Pakistan (Ali, Asad, Mogren, & Krantz, 2011), for example.

More direct evidence for the association between war exposure and intimate partner violence comes from a large representative study conducted in the territories of the Palestinian National Authority that comprised self-report data of 3.510 women (Clark et al., 2010). The study revealed that women whose husbands had been directly exposed to political violence were at an increased risk to be affected by physical and sexual partner violence when controlling for a range of socio-demographic variables (i.e. age, educational level, employment status of each partner, location (urban, rural, or camp), and region (West Bank or Gaza Strip)). In addition, the family's exposure to political violence independently predicted partner violence experienced by women. This finding gives rise to the question whether women's own exposure to political violence may also have contributed to their experience of domestic violence. Despite a general paucity of research on re-victimization in war-affected women, a study from Lebanon showed a significant positive correlation between women's exposure to war violence and past and ongoing exposure to domestic violence by the partner and the family (Usta, Farver, & Zein, 2008). Regarding male perpetration of intimate partner violence results from the WHO multi-country study showed that men's engagement in armed fights and involvement in gangs were independent predictors of intimate partner violence perpetration while controlling for men's exposure to childhood maltreatment, depression, alcohol abuse, low education and poverty (Fulu, Jewkes, Roselli, & Garcia-Moreno, 2013). In a South African epidemiological study men who had experienced higher levels of political violence were significantly more likely to indicate that they had pushed, grabbed, shoved, thrown something, slapped, or hit their most recent intimate partner (Gupta, Reed, Kelly,

Stein, & Williams, 2010). Thus, war may increase women's risk of experiencing violence from an intimate partner because war-affected male partners are more likely to perpetrate violence against women and war-affected female partners are more likely to be re-victimized in the context of their intimate relationship.

As yet, there are hardly any studies asking war-affected parents about their perpetration of child abuse. Studies that investigated children in post-conflict settings found a positive relationship between exposure to war-related violence and violent experiences in the family context. A large study that examined 1.185 Palestinian adolescents found that the family's exposure to organized violence increased children's risk of experiencing maltreatment at home (Haj-Yahia & Abdo-Kaloti, 2003). Studies from Sri Lanka and Afghanistan revealed that children's individual war-related exposure independently predicted higher levels of maltreatment (Catani et al., 2008, 2009).

Taken together, the findings above suggest that there is a link between organized violence and violence within the family. War may contribute to increased partner violence and more maltreatment of children.

2.3.3 Psychopathology as a mediating mechanism in the transmission of violence

As has been outlined above, collective as well as interpersonal violence generally showed a strong linkage to the development of externalizing behaviour problems in children and adolescents and predicted PTSD symptoms, depression symptoms and alcohol-related problems in adults (e.g. Campbell, 2002; De Jong, Komproe, & van Ommeren, 2003; Gilbert et al., 2009). A number of researchers have argued that posttraumatic psychopathological reactions may not be viewed as a mere outcome of traumatic experiences. Instead, trauma-related symptoms and PTSD in particular may constitute a factor that is intricately involved in the proliferation of violence across time and contexts (Catani, 2010; Pratchett & Yehuda, 2011; Taft, Watkins, Stafford, Street, & Monson, 2011). Support for the mediating role of posttraumatic stress symptoms in the re-victimization process comes from a longitudinal study that examined a nationally representative sample of 2.863 US women (Cougle, Resnick; & Kilpatrick, 2009). The authors found that women's re-experiencing symptoms were predictive of subsequent interpersonal victimization whereas women's hyperarousal symptoms were predictive of subsequent exposure to non-interpersonal traumatic events.

Psychopathological reactions after exposure to traumatic events have also been linked to an increased risk of perpetration. In male military veterans high levels of PTSD symptoms

resulting from traumatic war events were associated with an increased perpetration risk against female partners after return (Taft, Watkins, Stafford, Street, & Monson, 2011). Results from a cross-sectional study in Rwanda found that genocide survivors who perpetrated violence against their intimate partners displayed higher levels of psychopathological symptoms than victims of intimate partner violence and respondents unaffected by partner abuse (Verduin, Engelhard, Rutayisire, Stronks, & Scholte, 2013). A large epidemiological study in post-conflict Uganda found that higher levels of war-related trauma predicted higher levels of alcohol-related problems (Roberts et al., 2011). Alcohol-related symptoms in turn constitute one of the most consistently reported risk factors of male perpetration of violence against female partners (e.g. Fulu et al., 2013; Gage, 2005; Jewkes et al., 2002; Koenig et al., 2003).

Looking at parents' child abuse risk, a history of psychiatric illness in parents as well as maternal impulsivity, high negative affect, dysphoria and increased autonomic nervous system arousal have been linked to registered cases of child maltreatment (Black, Heyman, & Smith Slep, 2001; Sidebotham & Heron, 2006). Considering the obvious overlap between these symptoms and trauma-related psychopathological reactions including PTSD, the notion that posttraumatic psychopathological symptoms may mediate the intergenerational transmission of violence gains some face validity. And indeed, a number of studies suggest that ongoing posttraumatic psychopathological symptoms in caregivers increase dysfunctional and potentially violent parenting behaviours. For example, PTSD symptoms in male military veterans were associated with less positive parenting behaviours towards their offspring (Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010). Traumatized refugee mothers displayed more hostile parenting behaviours towards their children in direct behavioural observations (Van Ee, Kleber, & Mooren, 2012). And among maltreating mothers those with PTSD tended to abuse their children earlier in life (Famularo, Fenton, Kinscherff, Ayoub, & Barnum, 1993). Some researchers have concluded that PTSD in parents may be an essential mechanism underlying the intergenerational transmission of trauma and abuse (Yehuda, Halligan, & Grossman, 2001). However, conflicting evidence comes from studies conducted with civilian samples. For example, in a study that investigated maternal parenting in a sample of mothers who had been maltreated in childhood, PTSD symptoms did not emerge as an independent predictor of a higher self-reported child abuse potential, more punitiveness, more psychological aggression or physical discipline when taking the effects of depression, substance use disorder and cumulative trauma exposure into account (Cohen, Hien, & Batchelder, 2008). In another study childhood maltreatment in mothers was clearly

determined as a predictor of maternal psychopathology, social isolation and aggressive response bias. However, only the latter two variables emerged as significant mediators with respect to child victimization whereas maternal psychopathology was not associated with child abuse perpetration at all (Berlin et al., 2012). Other studies even reported that parental PTSD and depression were associated with less perpetration of child abuse when parents had a history of childhood maltreatment (Pears & Capaldi, 2001).

In sum, these findings suggest that posttraumatic stress symptoms and other psychopathological reactions resulting from previous trauma may increase the likelihood of male perpetration of partner violence and women's re-victimization in intimate relationships. However, results concerning the role of posttraumatic stress symptoms in the intergenerational transmission of violence remain inconclusive. While some studies found that parental psychopathology potentially contributes to parents' risk of abusing their child others do not.

Children themselves are not mere recipients of violence and certain child characteristics may be important determinants of escalating violence within the family (Krug et al., 2002). For example, children's own exposure to traumatic events outside the home predicted children's experiences of family violence in post-conflict settings (Catani et al., 2008, 2009). In western low-income high-risk environments exposure to community violence outside the home was negatively related to children's feelings of closeness and positive affect when they were with their caregivers (Lynch & Cicchetti, 2002). In Northern Ireland exposure to secular violence increased children's perception of emotional insecurity in the mother-child relationship (Cummings et al., 2012). In a violent environment children's dysfunctional efforts of adjustment directed at internal states and the external environment (Pynoos, Steinberg, & Piacentini, 1999) including internalizing and externalizing behaviour problems, socialized aggression, and impaired social competence with peers (Black, Heyman, & Smith Slep, 2001; Kim & Cicchetti, 2010) may play an important role in their (re-) victimization (Catani, 2010).

In sum, psychopathological symptoms in individual family members may accelerate the transmission of violence but they do not constitute a singular determinant of violent outcomes. In order to assess a person's risk of perpetrating or experiencing future violence it seems necessary to consider a combination of risk factors that exist within the individual as well as in the individual's environment.

2.4 Context matters: Socio-ecological systems models

Contextual factors play an important role in defining resilient versus adverse child health outcomes including low birth weight, injuries, behavioural problems, and child maltreatment (Sellström & Bremberg, 2006). Socio-ecological systems models that derive from the pioneering work of Uri Bronfenbrenner (1979) have been most frequently applied to organize potential risk and protective factors of children's development. The original model distinguished between different ecological systems that vary in proximity to the individual. These include the microsystem, the mesosystem, the exosystem and the macrosystem. The time dimension was represented by the chronosystem which describes the socio-historical circumstances and the patterning of events over time (Bronfenbrenner, 1979).

2.4.1 Socio-ecological systems models in the prediction of family violence

The field of violence research has made use of socio-ecological systems models in order to organize the multiple factors underlying the genesis and preservation of violence along different levels of the socio-ecological context. For example, Heise (1998) described an ecological framework to categorize risk factors of partner violence perpetration and victimization. The original framework was enhanced in the World Report on Violence and Health (Heise & Garcia-Moreno in Krug et al., 2002, pp. 87-113). In their multi-level model, the authors referred to individual risks that comprise of chronologically distal risk factors related to an individual's personal (victimization) history and proximal risk factors such as mental health impairment and substance-related disorders; microsystem variables that comprise of partner and relationship characteristics including marital conflict; exosystem or community variables such as low SES, low social cohesion, violent crime and relationship norms; and macrosystem variables describing societal characteristics that might be linked to violence.

Belsky (1993) investigated multi-level risk factors that were conducive to child maltreatment. The author differentiated between children's immediate context where he focused on parenting styles and parents' dispositions toward anxiety, depression and hostility; the community context where he considered social disorganization and a lack of social coherence as important determinants of child abuse risk; and the societal-cultural context where a society's violent history and attitudes toward violence and the use of corporal punishment were regarded as major risks. In the World Report on Violence and Health, Krug

and Dahlberg (in Krug et al., 2002, pp. 1-19) used an ecological model that classes risk factors of perpetration as well as victimization within the individual, the relationship, the community and the society context. In terms of child maltreatment the report distinguished child characteristics that increase a child's vulnerability (e.g. age, sex, or being a premature or handicapped infant); caregiver and family characteristics (e.g. parents' characteristics, violence between partners in the home, family structure and resources); community characteristics (e.g. low social cohesion); and societal factors (e.g. cultural values, structural inequalities, characteristics of the legal system, characteristics of the social welfare system, larger social conflicts and war, etc.).

2.4.2 Socio-ecological systems models in the prediction of child mental health outcomes

Socio-ecological systems models have been usefully applied in studies that investigated risk and protective factors of child mental health in high risk environments (Betancourt, Meyers-ohki, Charrow, & Tol, 2013). One prominent example is the ecological-transactional model that was formulated by Lynch and Cicchetti (1998) to conceptualize the relationship between community violence, child maltreatment and children's psychological adaptation over time. Regarding the influence of multi-level risks, the ecological-transactional model postulates that risk factors on each level directly affect individual children's psychological adjustment. Moreover, the model states that risk factors on one level of the socio-ecological context influence the occurrence of risks on other levels. This transaction of risk factors presumably results in an accumulation of risks across distal and proximal levels of children's ecology. Empirical evidence for the inter-contextual transmission of violence originally came from low-income urban neighbourhoods in the United States. Children's exposure to community violence was linked to subsequent maltreatment experiences within the family context particularly with respect to physical maltreatment. Maltreatment in the family in turn led to adverse mental health outcomes in children (Lynch & Cicchetti, 1998; Valentino, Nuttall, Comas, Borkowski, & Akai, 2012). In war-torn regions, Catani et al. (2008, 2009) found that children's level of war exposure predicted higher exposure to adverse events from the family violence spectrum. Both types of trauma, i.e. traumatic war events and family violence, independently predicted higher levels of posttraumatic symptoms in children. The accumulation of war-related traumatic events and experiences of family violence was associated with a higher PTSD prevalence in children in a dose-response effect (Catani et al. 2008). Other studies in post-conflict settings have confirmed the independent effects of

exposure to organized violence and family violence in the post-conflict period on child mental health outcomes in terms of PTSD symptoms (Catani et al., 2009), depression (Klasen, Oettingen, Daniels, & Adam, 2010) and internalizing and externalizing behaviour problems (Panter-Brick, Goodman, Tol, & Eggerman, 2011). A longitudinal study in Sierra Leone showed that war-affected youths who experienced ongoing family violence and hardship in the community were at high risk of maintaining high levels of internalizing symptoms or even experienced deterioration in mental health outcomes (Betancourt et al., 2012). Thus, in post-conflict settings the accumulation of violent experiences in different contexts manifests as a major threat to children's healthy development.

On the other hand, protective factors within the family system such as the quality of the dyadic relationship to at least one caregiver and positive parenting practices have been discussed as important modifying factors guiding children's developmental outcomes in the context of adversity (Gewirtz, Forgatch, & Wieling, 2008; Masten & Narayan, 2012). To date there is little systematic research on the protective function of a positive parenting in terms of children's psychological outcomes in post-conflict settings. One study conducted in the Gaza strip found that perceived parental support mitigated the relationship between traumatic exposure and children's PTSD symptoms (Thabet, Ibraheem, Shivram, Winter, & Vostanis, 2009). Another study that examined 108 Palestinian children aged 11 to 12 years reported that more perceived intimacy and love in the parent-child relationship enhanced children's psychological adjustment (Punamäki, Qouta, & El-Sarraj, 1997). However, in a later study the authors found that the protective function of maternal care disappeared when children perceived their fathers as highly hostile and rejecting at the same time (Punamäki, Qouta, & El-Sarraj, 2001).

In sum, the constellation of risk and protective factors that exist in different sub-systems of children's social ecology seems to be decisive regarding children's psychological adjustment.

2.4.3 An intergenerational ecological model: The complex relationship between intergenerational and contextual factors in the prediction of child mental health outcomes

In the framework of an ecological model intergenerational risks that potentially affect child outcomes are represented within the chronosystem. Sidebotham and Heron (2006) proposed a model in which parents' ontogenetic development (i.e. parental background

variables) affect the child directly as well as the microsystem (i.e. the family) and the exosystem (i.e. the socio-economic environment) in which the child develops. The authors investigated parental background variables (i.e. a history of childhood abuse, a history of psychiatric illness, low education and parental age), factors in children's socio-economic environment (e.g. indicators of poverty and economic deprivation), characteristics of the family environment (e.g. family structure) and children's characteristics (e.g. birthweight) in order to identify children who are at risk of experiencing abuse. Using longitudinal data of a cohort study that comprised of 14.893 pregnant mothers and followed 14.246 children up until infancy the author tested which factors were predictive of investigations and registrations for child abuse. They found that parental background variables including age, education, parents' psychiatric history as well as parents' experiences of family violence in their own childhood predicted investigations and registrations for child abuse. The relationship was partly mediated by economic factors such as living in poor environment. Family structure was not predictive of child abuse when parental background variables and socio-economic variables were taken into account. The authors suggested that other proximal factors within the family environment such as ongoing psychopathological symptoms in parents and dysfunctional parenting strategies that result from parents' own adverse childhood experiences may negatively affect children's outcomes (Sidebotham & Heron, 2006). Other studies showed that children of depressed parents (Hammen, Hazel, Brennan, & Najman, 2012) and traumatized parents (Brand, Hammen, & Brennan, 2011) were exposed to a higher number of childhood adversities (including parental death, parental marital conflict, and serious illnesses and accidents) and experienced more chronic and acute stress in their social environment. Elevated levels of stress experienced by children mediated the intergenerational transmission of depression (Hammen et al., 2012) and appeared to contribute to higher levels of PTSD later in life (Koenen, Moffitt, Caspi, Gregory, Harrington, & Poulton, 2008; Yehuda et al., 2001). In sum, it appears crucial to include both intergenerational factors as well as ecological stressors on multiple levels of children's environment in order to predict adverse child outcomes.

Studies in post-conflict settings that assess intergenerational as well as ecological risks are scarce. The few two-generational studies including guardians and children suggest that parental psychopathology may negatively influence child outcomes. For example a study in Gaza showed that mothers' mental health symptoms were associated with higher levels of distress in children when controlling for maternal war-related exposure (Qouta, Punamäki, & El Sarraj, 2005). Another study in the Gaza Strip reported an independent effect of parental

PTSD and anxiety symptoms on children's PTSD and anxiety symptoms even when controlling for children's own trauma exposure (Thabet, Tawahina, El Sarraj, & Vostanis, 2008). In Afghanistan there was a significant association between guardians' psychopathological symptoms and children's internalizing and externalizing behaviour problems, higher depression symptoms and high levels of PTSD symptoms when controlling for child exposure (Panter-Brick et al., 2009). The mediating role of factors in children's family environment was supported by the later finding that parents' psychopathological symptoms were no longer predictive of child psychopathology when controlling for children's exposure to family violence and family conflict in the post-conflict period (Panter-Brick, Goodman, Tol, & Eggerman, 2011). Taken together, children of victimized parents appear to be more vulnerable to encounter community-level stressors, stressors within the family system and stressors within the dyadic relationship with caregivers. This may partly be due to parents' own psychopathological reactions to previous victimization experiences. In post-conflict settings chronologically distal victimization experiences in parents include experiences of childhood maltreatment as well as exposure to traumatic war events.

On the other hand, characteristics of children's proximal environment may also mitigate the adverse effect of chronologically distal risk factors in parents. Tracing the continuity and discontinuity of harsh parenting across two generations Conger et al. (2012) demonstrated that a warm and supportive co-parent disrupted the intergenerational transmission of harsh and punitive parenting behaviour. In order to account for these complex modulations, family system models argue for the consideration of characteristics of both parents and the family at the same time (Appel & Holden, 1998).

Overall, child outcomes appear to be influenced by interrelated risk factors that can be organized along the chronological and the ecological dimension of the socio-ecological system model. Both chronologically distal risk factors such as parental exposure to violent experiences as well as ecological risk factors seem to account for the variability in child outcomes. Chronologically distal risks may combine with more proximal risks such as ongoing community violence in the post-conflict period, ongoing family violence and dysfunctional interactions between individual family members and mental health disorders in parents. The combination of risk factors within individuals (e.g. parental background variables including previous exposure to war-related trauma and a history of childhood maltreatment) and within multiple systems of children's environment (e.g. community, family, dyadic relationship, peer relationship) may be decisive in the identification of vulnerable children in post-conflict settings.

2.5 The socio-historical background of the war in northern Uganda and the social ecology of children growing up in the post-conflict period

The war in northern Uganda represented a prototypical example of the so-called "new wars" in which civilians become the primary targets of organized violence (Kaldor, 1999). In between 1986 and 2006 the Lord's Resistance Army (LRA) under the command of Joseph Kony waged a guerrilla war against the government army Ugandan People's Defense Force (UPDF). Although the majority of LRA fighters came from the Acholi and Langi tribes of the northern districts, the northern tribes and the Acholi in particular suffered most from the terrors of the LRA. The conflict was protracted over two decades as it was upheld by ethnic and political power struggles that were staged within Uganda as well as between the Ugandan and Sudanese governments. Nationally, the conflict helped to consolidate the predominance of the southern tribes. On the international stage, the Ugandan as well as the Sudanese side supported upheavals against their respective opponent in the pursuit of regional control. Within Uganda the government responded to the LRA insurgency by interdicting the northern districts while the LRA launched their attacks against the local population (Dolan, 2013; Doom & Vlassenroot, 1999; Internal Displacement Monitoring Center, 2010). The LRA resorted to the large-scale abduction of children and adults in the region to use them as porters, soldiers or "give them as wives" to their commanders. Furthermore, the LRA committed and publicly displayed acts of extreme cruelty, mutilated civilians (e.g. cutting off women's breasts, cutting off lips and ears, etc.) and forced persons to perpetrate atrocities (e.g. forcing someone to kill a family member) (Annan, Blattman, Horton, 2006; Bayer, Klasen, & Adam, 2007; Derluyn, Broekaert, Schuyten, & De Temmerman, 2004; Ertl et al., 2014; Human Rights Watch, 2003, 2009; Internal Displacement Monitoring Centre, 2012). The systematic violence employed by the LRA caused suffering on the individual level, led to profound changes in social entities including the family and the community and challenged basic social values (Kaldor, 1999; Hovil & Moorhead, 2002; Mekki-Berrada et al., 2001).

Starting from 1996 the Ugandan government urged almost the entire population of the northern regions to resettle into Internally Displaced Persons (IDP) camps (UNOCHA, n.d.). This action was taken as a counter-insurgency measure in order to protect the civilian population and to stop the LRA from looting supplies and forcibly recruiting people. In spite of these efforts epidemiological studies showed that in the Acholi sub-regions up to 49% of the adult population (Vinck et al., 2007) and up to 43% of adolescents aged between 12 and 25 years (Ertl et al., 2014) fell victim to abduction by the LRA. On an individual level, high

exposure to traumatic war events resulted in high prevalence rates of PTSD symptoms (15% to 74%) (Ertl et al., 2014; Vinck et al., 2007), depression symptoms (45% to 67%) (Roberts, Ocaka, Browne, Oyok, & Sondorp, 2009; Vinck et al., 2007) and alcohol-related symptoms (32% in men and 7% in women) (Roberts et al., 2011) in IDP populations. In addition, the crowded and poor living conditions in the camps and the inability to be economically self-sufficient facilitated the dissolution of the clan structure and led to an erosion of the cultural and social organization of traditional family and community life (Hovil & Moorhead, 2002). For example, in the face of the constant threat of abduction, men could no longer leave the camp to work on the fields whereas women were able to execute household chores within the camps. It has been speculated that idleness and the loss of social roles might have increased male residents' proneness to alcohol consumption and alcohol abuse which exacerbated escalating violence against women within the community and within the family (Akumu, Amony, & Otim, 2005). The life-time prevalence of emotional, physical or sexual partner violence experienced by married women in the camps was estimated to be as high as 62% (Uganda Bureau of Statistics, 2006). More than half of the women living in the camps (52%) were affected by ongoing violence perpetrated by an intimate partner (Stark & Ager, 2011). Children also faced a desperate situation in the camps with high mortality rates during infancy (106 deaths per 1000 live births), restricted access to education (74% primary school attendance, 3% secondary school attendance among school aged children) and more than one quarter of children (27%) had to cope with the death of at least one parent (Uganda Bureau of Statistics, 2006).

In 2006 peace negotiations with the LRA achieved a ceasefire so that by 2007 active fighting had ceased and the displaced population slowly expanded into satellite camps (Internal Displacement Monitoring Centre, 2012). In between 2008 and 2010, 92% of the internally displaced persons in the Acholi region left the camps to re-build their homes on their traditional land (UNOCHA, n.d.). However, extreme poverty, a largely insufficient infrastructure, limited access to education and health care, food insecurity, land disputes and persistent violence in the communities remained major challenges to returnees (Internal Displacement Monitoring Centre, 2012). War-related loss, premature death due to HIV/AIDS and the need for parents to leave children behind to rebuild their homes resulted in the disintegration of families and profound alterations in family structure (Ministry of Gender, Labour and Social Development, 2009). Unlike their parents a majority of children growing up in the post-conflict years in northern Uganda may barely remember the horrors of war. But children in the post-conflict setting are faced with a multiplicity of secondary adversities that

outlasted the end of the war and remain as impediments to children's healthy development (Steinberg, Brymer, Decker, & Pynoos, 2004).

2.6 Conceptual framework of the current study: The application of an intergenerational ecological model in a post-conflict setting

As has been described above the war in northern Uganda has had a profound impact on the individual level, the family system level and the community level. Consequently, a conceptual model of risks that directly and indirectly facilitate the transmission of violence in the post-conflict period and adversely affect child outcomes needs to include several levels of analyses. In the current study we examined intergenerational and ecological risks with respect to (a) inter-parental interactions, (b) dyadic interactions between parents and children, (c) family interactions involving both guardians and the child, and (d) child mental health outcomes in the post-conflict period. Dysfunctional inter-parental interactions (a) were operationalized as male-to-female partner violence. Positive and negative dyadic interactions between parents and children (b) were operationalized in terms of parental care and aggressive parenting behaviours from the parent to the child. Violent family interactions (c) were represented by violent acts between family members that were witnessed and/or experienced by the child including parent-to-child violence, parent-to-sibling violence, and inter-parental violence. Child mental health outcomes (d) were operationalized as psychopathological symptoms in children including PTSD symptoms, depression symptoms, internalizing and externalizing behaviour problems, suicidal ideation and functional impairment.

Risk factors of ongoing violent interactions between guardians (a) were organized along the time dimension while controlling for socio-economic status. Individual risk factors in both male and female partners were included in the model to predict partner violence experienced by women. We considered a history of childhood family violence and exposure to war-related violence as chronologically distal risks in guardians. Ongoing psychopathological symptoms in guardians were included as chronologically proximal individual risks. Adult psychopathological symptoms were operationalized as higher levels of PTSD symptoms, depression symptoms, alcohol-related symptoms, suicidality, and functional impairment in daily tasks.

Regarding family violence against children we used a similar conceptual approach as Sidebotham and Heron (2006) and considered parental background variables, risk factors in children's socio-economic context, risk factors in children's family environment and child characteristics in our model. In particular we included guardians' history of childhood maltreatment and the level of war-related exposure as parental background variables, guardians' PTSD, depression and substance-related symptoms as proximal guardian risk factors, children's exposure to community-level traumatic events as risk factor in children's socio-economic environment, inter-parental violence as risk factor in children's family context and individual characteristics of the child (i.e. being the biological child) in the model. Risk factors were tested in relation to (b) guardian-reported aggressive parenting strategies in dyadic interactions with the child and with regard to (c) maltreatment children experienced within the family context (excluding witnessed violent events). Concerning the family system level, the model holds that individual risk factors in both guardians and the child combine with characteristics of the family environment (e.g. inter-parental violence) to determine children's risk of experiencing maltreatment within the family.

In the prediction of child psychopathology (d) we included all levels of analysis and organized risk factors according to their proximity to the child. Guided by ecological systems models we included traumatic events on the community level (i.e. traumatic events outside the family) as ecologically distal risk. Loss of at least one parent was also conceptualized as distal risk because it was a sad or traumatic experience children encountered outside of the present family context. Violent interactions in the family context represented a family-level risk. These included parent-to-child violence, parent-to-sibling violence and inter-parental violence. Low parental care in the dyadic relationship between the individual parent and the child was seen as proximal risk. The model proposes that risk factors on each level contribute to increased psychopathological symptoms in children. In accordance with the transactional ecological model by Lynch and Cicchetti (1998) we also proposed that risk factors on one level affect risk factors on the other level (e.g. traumatic experiences in the community context are associated with more family violence which in turn negatively affects child-perceived parental care). As has been outlined above, the model implies that ecological transactions are influenced by chronologically distal intergenerational risk factors (i.e. previous victimization experiences in guardians) as well as proximal guardian risk factors (i.e. psychopathology in guardians) that need to be controlled for on each level.

Figure 1 summarizes the conceptual model of the present study and gives an overview of the risk factors and levels of analysis that were included. Several additional control

variables were also considered in our analyses: On the community level we controlled for location of the community to adjust for potential cluster effects. On the family system level we controlled for the family's socio-economic status. On the individual level characteristics such as age and gender of child were routinely controlled for.

In the analyses presented in this thesis we mainly focused on the interplay between individual risks and characteristics of the family environment in order to predict violence against women in the context of their intimate relationship, family violence against children and adverse child mental health outcomes. Other works that used data from the current study relate to the association between family violence, school violence, peer reputation and psychopathological symptoms in children. Results are briefly summarized in section 5 under the heading *Additional works and further developments.*

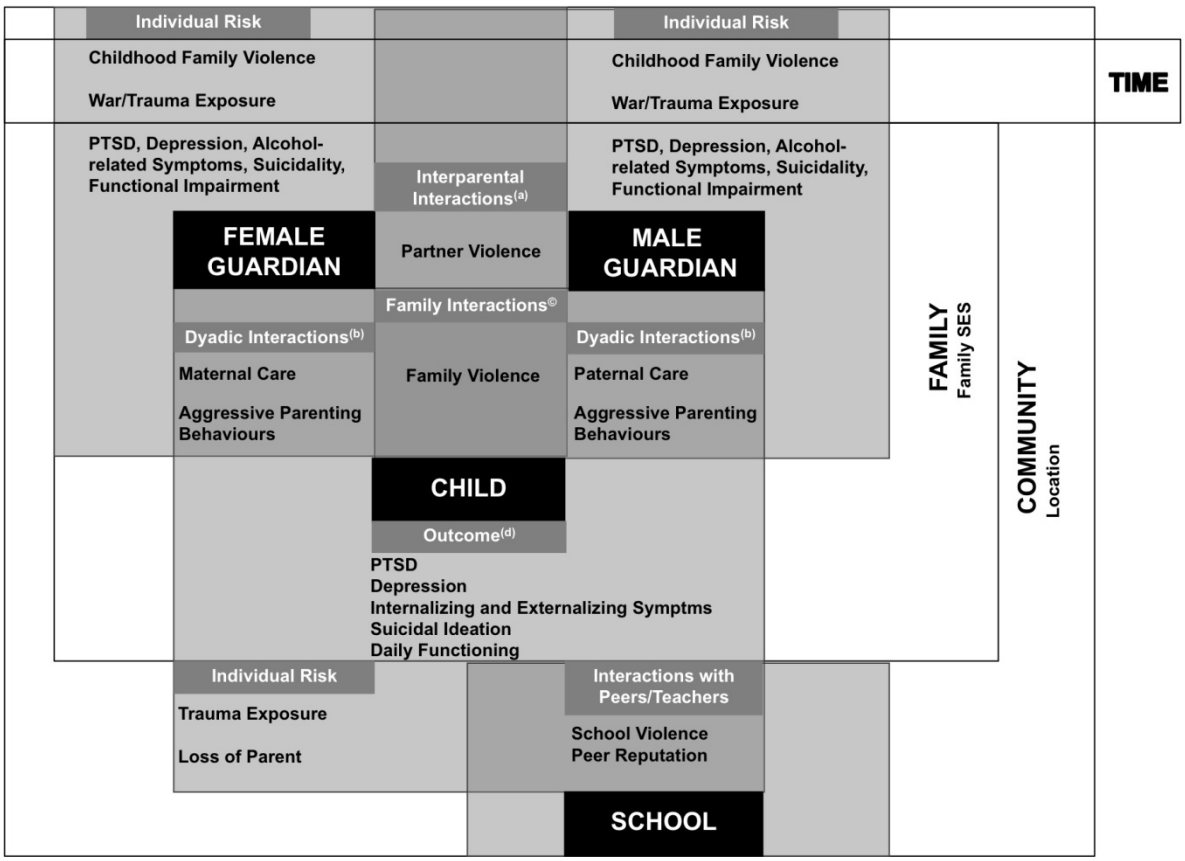

Figure 1.

Conceptual model

2.7 The relevance of applying an intergenerational ecological model to violence and intervention research in post-conflict settings

The review of the current literature showed that persons living in resource-poor countries in the sub-Saharan African regions experience the highest levels of violence worldwide with respect to collective as well as interpersonal violence (Krug et al., 2002). Exposure to war violence imposes a considerable burden on individual mental health (e.g. De Jong et al., 2001; Neuner et al., 2004) as well as family functioning (Gewirtz, Forgatch, & Wieling, 2008; Masten & Narayan, 2012). In particular, previous war exposure appears to increase the level of family violence against women and children in post-conflict settings (Catani et al., 2008, 2009; Clark et al., 2010; Haj-Yahia & Abdo-Kaloti, 2003; Usta et al., 2008). It has been hypothesized that the relationship between war exposure and family violence in the post-conflict period may partly be mediated by increased levels of posttraumatic stress symptoms in caregivers (Catani, 2010). Previous exposure to war violence in veterans has also been linked to a higher perpetration of violence in intra-familial dyadic interactions (e.g. Gewirtz et al., 2010; Samper, Taft, King, & King, 2004; Taft et al., 2011); i.e. victims of war violence appear to be more likely to perpetrate violence against their intimate partner and to maltreat their children.

In the post-conflict period the "spillover" (Bronfenbrenner, 1986) from war to family violence impedes economic development and hampers effective peace building in war-affected societies (Wessells & Monteiro, 2001). In post-conflict settings the transmission of war to family violence annihilates child protection efforts and adversely affects children's mental health in (e.g. Catani et al., 2008, 2009; Klasen, Oettingen, Daniels, & Adam, 2010; Panter-Brick et al., 2011). Mental health conditions contribute to reduced development through a vicious cycle of mental health impairment, increased vulnerability to adverse experiences (e.g. marginalization, re-victimization, etc.), reduced development and worsened mental health (World Health Organisation, 2010).

In the realm of complex emergencies that incorporate all types of violence, psychological research and intervention make a significant contribution to social recovery by identifying risk factors that perpetuate the transmission of violence and by directing treatment to those who face the greatest risk (Silove, 2004). Scientists and practitioners in the field of mental health care in post-conflict developing countries have argued for multi-level interventions that target the individual as well as the family (Betancourt et al., 2013). As resources allocated to mental health services are often limited in these contexts effective

treatment depends on the unerring identification of cases and the purposeful matching of evidence-based treatments to the target condition on each level (Belkin et al., 2011).

In war-affected populations that suffer from high levels of ongoing interpersonal violence it appears mandatory that prevention programmes target ongoing violence in the family context (Krug et al., 2002) in order to protect the mental health of guardians as well as children. As war violence affects individual family members and the family as a whole interventions need to target the individual and the family in order to mitigate the adverse short- and long-term effects of different types of violence. However, the development of targeted multi-level programmes has been hampered because to date research on risk factors that contribute to the experience of family violence in post-conflict settings has largely focused on women and children as individuals (e.g. Betancourt et al., 2010; Catani et al., 2008, 2009; Clark et al., 2010; Haj-Yahia & Abdo-Kaloti, 2003; Panter-Brick et al., 2011). There is a paucity of research that take the individual effects, relationship effects on a dyadic level and family effects (Appel & Holden, 1998; Cook, 1994) into account.

2.8 Overall objective of the current work

The current study was located in northern Uganda as a prototypical example of a severely war-affected post-conflict setting in the African regions. The overall aim of the research project was to employ a comprehensive conceptual framework that considers multiple actors and multiple levels of analysis (i.e. the individual level, the dyadic relationship level and the family level and the community level) to use for data collection and analyses. We aimed at the generation of empirically based, locally relevant knowledge that helps to prevent ongoing family violence against women and children in post-conflict northern Uganda and can be used to support children's healthy psychological development in the context of the post-conflict setting. In particular, we investigated the interplay of ecological and chronological risk factors in order to identify relevant risks to family functioning and individual adjustment. With the current work we intended to identify treatment needs of war-affected northern Ugandan families in the post-conflict period and to provide useful information for the development, coordination and implementation of interventions on the individual level, the dyadic relationship level and the family system level.

2.9 Specific objectives and hypotheses

In order to disentangle the complex interplay of intergenerational and ecological risks in the prediction of adverse outcomes, we used the proposed conceptual framework to guide the analyses of specific components in the model in meaningful steps. We first focused on the prevalence and risk factors of partner violence against women as one key component in the transmission of violence (a). Second, we investigated dyadic and triadic interactions to identify independent risk factors of family violence against children (b and c). Finally, we examined the interplay of intergenerational risks and risk factors on the community level, the family system level and the dyadic relationship level in the prediction of child mental health outcomes (d). These analyses constitute the core manuscripts of the cumulative dissertation. Other works have focused on additional aspects of the model. These will be discussed in brief in section 5.

2.9.1 Partner violence against women in post-conflict northern Uganda

Studies conducted in IDP camps in northern Uganda suggested that women in the conflict-affected regions experienced higher levels of ongoing intimate partner violence compared to Ugandan women living in the peaceful south (Koenig et al., 2003; Stark et al., 2010; Uganda Bureau of Statistics, 2006). To date very little is known about the extent of partner violence experienced by women in the transition phase when most of the formerly displaced have returned or moved closer to their original land. Furthermore, the studies mentioned above have largely focused on physical and sexual partner violence. Little is known about the extent to which women are affected by other types of abusive behaviours from their partners including emotional abuse, economic violence and isolation from friends and families. Although previous research in post-conflict settings suggested that male partners' exposure to political violence (Clark et al., 2010) as well as women's exposure to war (Usta et al., 2008) and abduction (Annan & Brier, 2010) may contribute to higher levels of domestic violence experienced by women, there is a paucity of research that examines both partners as couples. In the context of northern Uganda where both partners have been affected by high levels of war-related traumatic events we examined independent risk factors in both partners in order to predict higher levels of abuse experienced by women. We assessed multiple types of partner violence including psychological violence, physical violence, sexual violence, and deliberate isolation. The present study targeted two simultaneous processes that

potentially contribute to women's experience of partner violence in the aftermath of war: We examined potential risk factors that increase women's risk of being victimized as well as risk factors that potentially contribute to male perpetration. We hypothesized that chronologically distal risk factors in each partner (i.e. a history of childhood maltreatment, traumatic war exposure and long-term abduction) as well as proximal risks (i.e. re-experiencing symptoms in female partners and PTSD symptoms, depression symptoms and alcohol-related symptoms in male partners) would contribute to higher levels of ongoing partner violence experienced by female partners.

2.9.2 Family violence against children in post-conflict northern Uganda

Amongst transitional and developing countries worldwide parents in the African regions show the highest rates of abusive behaviours towards their children (Akmatov, 2011). Children in Uganda report high levels of violence experienced from family members (Naker, 2005), but systematic data on children's experience of family violence in the war-affected northern regions of Uganda is lacking (Ministry of gender, labour and social development, 2009). The World Health Organisation emphasizes the importance of epidemiological research in the prevention of child maltreatment by "suggesting priorities for prevention among those at high risk of either experiencing or perpetrating child maltreatment, as well as priorities for addressing the associated risk factors" (Butchart, Harvey, Mian, & Fürniss, 2006, p. 17). To date, the few studies that have addressed the issue of family violence against children in post-conflict settings point to elevated levels of child maltreatment (e.g. Catani et al., 2008, 2009; Haj-Yahia & Abdo-Kaloti, 2003; Klasen et al., 2010; Panter-Brick et al., 2011). Although it has been hypothesized that war may increase aggressive parenting behaviours (Catani, 2010; Straus, 2010; Ember & Ember, 1994), there is a paucity of research regarding the perpetration potential in war-affected guardians. In addition, it is yet unclear whether the identification of guardians who are at an increased risk of perpetration will suffice to identify children at risk of being victimized. Within the family system partner effects (e.g. partner violence) in addition to individual risks may contribute to children's victimization (Appel & Holden, 1998; Belsky, 1993; Conger et al., 2012). In an effort to create useful knowledge for the prevention and reduction of violence against children in northern Uganda we first aimed at identifying risk factors in individual guardians that predict guardian's child abuse potential while taking child characteristics into account. In order to determine children at risk of being victimized in the family, the present study aimed at the

identification of risk factors in children's proximal environment including individual risk factors in parents and children as well as risk factors of child victimization on the family system level. We hypothesized that distal victimization experiences in guardians (i.e. childhood victimization, war exposure) as well as proximal risk factors (i.e. marital violence and psychopathological symptoms including alcohol-related symptoms) would increase guardians' likelihood to perpetrate violence against their child. At the same time we assumed that children with high exposure levels to previous traumatic events outside the family context are at an increased risk of being re-victimized in dyadic interactions with their guardians. Regarding child-reported maltreatment experiences in the family we assumed that family-level variables (i.e. disruption of family relations and children's perception of violence between adults in the household) would make an independent contribution in addition to individual risk factors in both guardians and children in the prediction of children's victimization risk.

2.9.3 Ecological and intergenerational risks of child psychopathology in post-conflict northern Uganda

Children living in post-conflict settings face a multitude of adversities in their proximal environment (e.g. disruptions in family composition, inter-parental violence, parental psychological impairment and substance abuse in parents etc.). On the community level poverty, reduced access to education, low cohesion and high levels of community violence often persist as the consequences of war (Pynoos et al., 1999). Both exposure to traumatic events and exposure to family violence have been shown to independently predict adverse mental health outcomes in children and adolescents (Klasen et al., 2010; Olema, Catani, Ertl, Saile, & Neuner, 2014; Panter-Brick et al., 2011). In Sierra Leone ongoing family violence after the end of war obstructed the recovery of traumatized children and even led to a deterioration in mental health outcome in terms of internalizing problems (Betancourt et al., 2012). On the other side positive parenting practices potentially buffer the negative impact of traumatic exposure on children's mental health (Gewirtz et al., 2008; Thabet et al., 2009; Masten & Narayan, 2012; Stichick Betancourt & Khan, 2009). Recommendations for the promotion of child mental health in post-conflict settings stress the need for interventions on the individual level, the relationship level and the family system level (Betancourt et al., 2013). Despite the undoubted usefulness of a multi-level approach in child mental health care, concerted interventions on multiple levels require a sound understanding of the interplay of

risk factors on different levels of children's ecology. To date little is known about the way in which community factors, family factors, relationship factors, and individual factors combine to affect children's mental health in the post-conflict period. Very few studies have considered parental trauma exposure as an intergenerational risk (e.g. Palosaari, Punamäki, Qouta, & Diab, 2013; Qouta, Punamäki, & El Sarraj, 2005) and there are no studies that investigate ecological as well as intergenerational risk factors at the same time.

In the current work we employed the conceptual model described above to identify risk factors of child psychopathology on multiple levels of children's ecology while controlling for intergenerational risks in female guardians. We focused on children and their female guardians based on the assumption that female guardians in northern Uganda traditionally provide more caregiver support and are thus more central to young children's immediate rearing environment than male guardians (Karimli, Ssewamala, & Ismayilova, 2012). We hypothesized that children's exposure to general traumatic events in the community context, children's exposure to violence in the family (i.e. inter-parental violence, parent-to-child violence and parent-to-sibling violence) and less perceived care in their dyadic relationship with female guardians would independently contribute to higher levels of psychopathological symptoms in children. In addition we predicted that caregiver characteristics such as previous victimization experiences during childhood and in the course of the war and ongoing psychopathology would negatively affect children's psychological adjustment. In order to better understand the dynamics that increase children's psychological vulnerability in the post-conflict period, we further explored direct and indirect risk trajectories. We proposed that risk factors on the community level, the family system level and the dyadic relationship level are associated, even when controlling for the intergenerational effect of guardian risk factors.

3 Methods and Procedure

Study design and time frame

In 2010 we conducted a cross-sectional epidemiological study that comprised 1.391 participants from 516 different families in nine communities (Bwobomanam, Cubu, Binya, Agweno, Orapwoyo, Lakwana, Idure, Koch Lila, Koch Kalang) in Gulu and Nwoya Districts in northern Uganda (see Appendix 1 for a map). The study proceeded in two waves of data collection: The first wave was conducted at two suburban schools (Bwobomanam and Cubu). Primary targets of the study were war-affected families with a child in second grade. At the first school we interviewed only children and their female guardians but decided to include male guardians from the second school on. After interviews at the first two schools, we refined our measures to assess intimate partner violence and alcohol-related problems because data from the first two schools indicated that the scope of the problem demanded closer attention. At all schools, teachers and peers rated individual children's emotional and behavioural problems and social behaviour.

Preparations

Ethical approval was obtained from the ethics committee of the German Research Foundation (DFG), the Ethical Committee of Gulu University in Gulu, Uganda, and the National Council of Science and Technology (UNCST) in Kampala, Uganda. In the preparation phase we also sought approval from Local Government Departments including the District Education Offices of Gulu and Nwoya Districts as well as Local Councils at the sub-county and community levels. Eligible schools were visited before the study. Headmasters and teachers were told about the study rationale, content and procedure and were asked for their cooperation.

Sample selection

In the present study we aimed to assess war-affected families with a child that grew up in the post-conflict period. We opted for families with a P2 (second-grade) student because children in P2 are on average in between 8 and 9 years old, which means they were infants when war violence peaked in northern Uganda. At the same time we expected that children who had successfully passed their first year of formal education would possess the cognitive ability to sit a 1 to 2 hour interview and respond to the interview questions. Since we intended to recruit children and their male and female guardians via schools we obtained a list of all

schools in Gulu and Nwoya Districts. However, after consulting with the DEO (district education officer) we decided against a random sampling of schools because many were not accessible by vehicle. Instead we used a two-stage selection procedure with a first non-random stage of cluster selection. We purposefully selected the group of clusters (communities) that together could contain all the variability of the overall target population (Vallée et al., 2007). We selected two schools from (sub-)urban communities close to Gulu Municipality and seven schools from rural communities. The clusters were chosen because after the end of the war Gulu town had rapidly emerged as commercial and developmental centre in the region, whereas former IDP camps outside town had undergone a gradual process of dissolution. Among rural sites we selected communities in the periphery of former IDP camps because at the time of the survey an estimated 92% of the internally displaced persons in the Acholi region had left the camps and returned to their communities of origin or settled in locations closer to home (UNOCHA, n.d.). Consultations with administrative and school staff in the IDP camps revealed that within the camps a selection of highly functional individuals such as business men and highly dysfunctional individuals such as severely mentally ill or substance dependent persons had remained and that the families of those individuals usually lived in the villages outside the camps. Rural communities were varied according to their distance to Gulu town because we assumed that secondary adversities such as poverty, restricted access to education and health care would increase with distance from Gulu town. Three schools were located in the remote area of Odek Subcounty and two schools were selected in Lalogi Subcounty in between Gulu town and Odek. Another two schools were sampled in Koch Goma Subcounty in Nwoya District which was around as far from Gulu as Lalogi Subcounty but more comparable to Odek Subcounty in terms of relative war exposure. In our analyses we routinely entered location as a fixed factor to control for potential cluster effects. Because we were interested in the sub-group of war-affected families who had a young child we then stratified the sample. Our key variable was having a child in P2. In order to achieve a good representative sample of our stratum population we exhaustively sampled all families that had a child in P2 within our purposefully selected cluster. Given that a considerable proportion of children in northern Uganda do not stay with their biological parents, we defined guardians as adult persons living in the same household and being primarily responsible for taking care of the child's upbringing, education, and the fulfilment of the child's material and emotional needs. Table 1 contains an overview of selected communities, locations and participant numbers.

Table 1

Communities, locations and participant numbers

	Name of school	Children	Primary female guardians	Primary male guardians	Subcounty	District	Location of School
1	Bwobomanam	68	68	-	Alokulum	Gulu	suburban
2	Cubu	80	80	58	Gulu Municipality	Gulu	suburban
	First wave total	148	148	58			
3	Binya	49	49	37	Odek	Gulu	rural
4	Agweno (Lakim)	46	46	38	Odek	Gulu	rural
5	Orapwoyo	39	39	33	Odek	Gulu	rural
6	Lakwana	85	83	74	Lalogi	Gulu	rural
7	Idure	76	76	63	Lalogi	Gulu	rural
8	Koch Lila	37	37	32	Koch Goma	Nwoya	rural
9	Koch Kalang	36	35	27	Koch Goma	Nwoya	rural
	Second wave total	368	365	304			
	Total number	**516**	**513**	**362**			

Measures

Luo versions of several instruments in the battery had already been created according to recommended procedures in transcultural research (Flaherty et al., 1988) for use in an earlier epidemiological study (Ertl et al., 2010, 2014). Remaining instruments were translated considering suggestions of Van Ommeren, Sharma, Thapa, Makaju, Prasain et al. (1999) using translation, lexical back translation as well as blind back translation procedures. After the review of translated items by the research expert discrepancies were discussed extensively with the group of local translators in order to optimize conceptual, criterion and semantic equivalence. After the first round of discussions translated items were again reviewed and discussed by a group of bilingual local therapists who were experienced in the field of mental health research in the region. Issues of comprehensibility, acceptability and relevance to the local culture were considered. Finally we re-examined translated items during the first wave of data collection within a focus group that consisted of study participants.

We adapted the socio-demographic questionnaire to include detailed information on family composition in addition to items covering age, gender, ethnicity, religious denomination, education level, household possessions, source of income and a history of

displacement and abduction. Questionnaires for men, women and children differed slightly to minimize redundant information. We created an instrument to record functional impairment in men, women and children according to an approach outlaid by Bolton & Tang (2002). Standardized free listing interviews were conducted in a convenience sample consisting of 24 men, 28 women, 10 boys and 11 girls. The author and two research assistants asked participants to describe typical age and gender specific daily tasks that men, women and 8-year-old boys and girls are expected to accomplish in the personal domain, in the family context and in the wider context of the school and community (see Appendix 2 for specific instructions). The three most frequently mentioned tasks from each domain and one open question were included in the final functioning questionnaires for men, women and children. Given that boys' and girls' tasks almost completely overlapped we used the same items for both sexes in children. For adults one question addressing impairment in sexual interest/activity was included since taboo domains could not be expected to emerge from the free listing interviews (Bolton & Tang, 2002). In order to confirm the cross-cultural validity of instruments assessing parenting practices we conducted focus groups with participants from the first two schools. In the groups we pursued another free listing approach asking participants several questions on expected child behaviour, general parenting practices and parenting behaviours in difficult situations with the child (i.e. "What are difficult situations with your P2 child?" "How do you behave towards your child in difficult situations?" see Appendix 3 for details). Responses to the latter question were simply compared to the items on the Parent-Child Conflict Tactics Scales (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998). A considerable overlap between participants' recorded answers and items covering non-violent discipline, psychological aggression and corporal punishment supported the utility of the CTSPC items in this context. We slightly adapted items to include culture specific parenting behaviours and to fit the interview format. For example the item *Hit him/her on the bottom with something like a belt, a hairbrush, a stick or some other hard object* was changed into *Did you hit him/her on the bottom with something like a belt, a mingling stick, a stick or some other hard object?*. Items on severe and very severe maltreatment were left unchanged because we did not expect them to emerge in the focus group discussions. We refrained from further content analysis of focus group discussions because further changes would have jeopardized comparability of the CTSPC and an in-depth qualitative analysis of focus group discussions was not the focus of the survey.

While we employed a limited number of items on physical, sexual and verbal abuse by an intimate partner and patterns of alcohol and substance consumption within the first two

schools we included the Composite Abuse Scale (CAS; Hegarty, 2007) and the Alcohol Use Disorder Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders, & Monteiro, 2002) from the third school on. Based on consultations with the local counsellors and participants we only assessed partner violence directed against women because men were not expected to report abuses by their wives due to local ideologies of masculinity. We a priori omitted the CAS subscale Harassment because we considered items contextually inappropriate (e.g. the item *Harassed me over the telephone* was excluded because the vast majority of women did not possess a phone or lived in an area with neither electricity nor network coverage). In order to create a more reliable measure of standard drinks we generated a table that contained different types of alcoholic beverages in northern Uganda and units in which alcohol is commonly sold and consumed. The local interviewers used the table to convert the consumed beverages into standard drinks on the basis of amount taken and the specific alcohol content (Babor et al., 2002).

The assessment of peer reputation with the original version of the Revised Class Play (Masten, Morison, & Pellegrini, 1985) proved infeasible under conditions of more than 80 students per class who were not yet able to read and write. We had to shorten the instrument and opted for an interviewer-assisted procedure instead of written self-report. For the short version of the RCP we selected the five items on each subscale that had the highest factor loadings in the original validation sample (Masten et al., 1985). If selected items appeared culturally inappropriate (which was the case for some disruptive behaviours) they were replaced by items with a comparable factor loading and more relevance to the local context. The final instrument consisted of 15 items covering the subscales Sociability Leadership (Cronbach's $\alpha = .84$), Social Isolation (Cronbach's $\alpha = .66$) and Aggressive/Disruptive (Cronbach's $\alpha = .82$).

The final set of instruments for guardians, children, teachers and in-class assessment of peer reputation is shown in tables 2a-c.

Table 2a

Set of instruments used in adult interviews.

Guardians		
Instrument	Author	Description
Socio-demographic Questionnaire	Adapted from Ertl et al. (2010, 2014)	Age, sex, marital status, family composition, socioeconomic information, religious denomination and practice, education, ethnicity, displacement and abduction history, war-related loss of first grade relatives
Physical Health Assessment (PHA)	Ertl et al. (2010, 2014)	Prevalence of chronic disease and one month prevalence of common diseases
Alcohol Use Disorder Identification Test (AUDIT)[a]	Babor et al. (2002)	Frequency and amount of alcohol consumption and alcohol-related psychopathological symptoms
Violence War and Abduction Exposure Scale (VWAES)	Ertl et al. (2010, 2014)	Event list with different event types covering general traumatic events, war-related traumatic events, LRA-specific events and forced perpetration
Posttraumatic Diagnostic Scale (PDS)	Foa (1995)	PTSD symptoms
Hopkins Symptom Checklist Depression section (DHSCL)	Derogatis, Lipman, Rickels, Uhlenhuth, & Covi (1974)	Depression symptoms
Mini International Neuropsychiatric Interview (MINI) Module C (Suicidality)	Sheehan et al. (1998)	Suicidal ideation
Luo Functioning Scale (LFS) for adults	Adapted according to Bolton & Tang (2002)	Daily functioning
Event list for aversive experiences at home	Adapted by Catani et al. (2008)	Maltreatment experiences in childhood
Composite Abuse Scale[b] (CAS)	Adapted from Hegarty (2007)	Partner violence experienced by women
Parent-Child Conflict Tactics Scales (CTSPC)	Straus et al. (1998)	Non-violent and aggressive parenting behaviours in difficult situations with the child
Strengths and Difficulties Questionnaire (SDQ) – parent form	Goodman (2001)	Parent rating of emotional and behavioural symptoms in children

Note. [a]Included after interviews at the first two schools. Before we used the Drug Usage Scale as described by Ertl et al. (2014)
[b]Included after interviews at the first two schools in women's interview sets only. Before self-created items on physical and sexual partner violence and a shortened version of the CTS-2 (Straus, 2007) had been used

Table 2b

Set of instruments used in child interviews.

Children		
Instrument	Author	Description
Socio-demographic Questionnaire	Adapted from Ertl et al. (2010, 2014)	Age, sex, marital status, family composition and relationships, meals per day, religious denomination and practice, ethnicity, displacement and abduction history, war-related loss of first grade relatives
Physical Health Assessment (PHA)	Ertl et al. (2010, 2014)	Prevalence of chronic disease and one month prevalence of common diseases
Violence War and Abduction Exposure Scale (VWAES)	Adapted from Ertl et al. (2010, 2014)	Shortened event list with different event types covering general traumatic events, war-related traumatic events, LRA-specific events and forced perpetration
UCLA PTSD Index for DSM-IV (UPID)	Pynoos, Rodriguez, & Steinberg (1998)	PTSD symptoms
Children's Depression Inventory (CDI) – Short Version	Kovacs (1992)	Depression symptoms
Mini International Neuropsychiatric Interview for Children and Adolescents (MINI KID) Module B (Suicidality)	Sheehan et al. (1998)	Suicidal ideation
Luo Functioning Scale (LSF) for 8-year-old children	Adapted according to Bolton & Tang (2002)	Daily functioning
Event List For Aversive Experiences at Home	Adapted by Catani et al. (2008)	Maltreatment experiences in the family context
Event List for Aversive Experiences at School[a]	Shortened and adapted version of the Event List for Aversive Experiences at Home	Experiences of verbal, physical or sexual violence at school
Parental Bonding Instrument (PBI) – Subscale Parental Care; mother and father form	Parker (1998)	Perceived parental care
Strengths and Difficulties Questionnaire (SDQ) – self-report form	Goodman (2001)	Emotional and behavioural symptoms reflecting internalizing and externalizing behaviour problems

Note. [a]Included in the fourth school (Agweno)

Table 2c

Set of instruments used in teacher and peer ratings.

Teacher ratings		
Instrument	Author	Description
Strengths and Difficulties Questionnaire (SDQ) – teacher report form	Goodman (2001)	Teachers' perception of internalizing and externalizing behaviour problems; in the second study phase introductory questions assessing the time and level of acquaintance and scholastic performance level of the student were added
Peer Ratings		
Instrument	Author	Description
Shortened Version of the Revised Class Play (RCP)	Adapted from Masten et al. (1985)	15-items assessing peer reputation in the domains Sociability Leadership, Social Isolation and Aggressive/Disruptive Behaviour

Validation study

In the third, fourth, fifth and sixth school we conducted a validation study to evaluate the validity of the Luo self-report version of the SDQ. The definition of "caseness" using the SDQ has been derived from the banding of SDQ scores in British norm samples. Cut-off scores were adjusted so that 80% of children in the community were in the normal band, 10% were in the borderline range and 10% were diagnosed as abnormal (Goodman, Meltzer, & Bailey, 1998; Goodman, 1997, 2001). To establish comparability of samples we stratified our sample along the same proportions. Interviews at the first two suburban schools suggested that 80% of children had a total difficulties score ranging from 0 to 10 and 20% of children scored 11 and above. After interviews at the first rural school confirmed the utility of the cut-off criterion to differentiate between the normal band and the borderline and abnormal band we grouped children into a highly symptomatic and a normal group along the SDQ total difficulties cut-off 11. In order to obtain an equilibrated subsample with 50% high-scorers and 50% low-scorers for the validation study we randomly selected an equal number of children from each group. A sub-sample of $N = 58$ children was re-interviewed by clinical psychologists on the basis of the Youth Self-Report Form of the Achenbach System of Empirically Based Assessment (Achenbach, 1991) as gold standard. Good concurrent validity and significant correspondence with expert judgement of clinically relevant symptom levels ($\kappa = .36$) were found. The optimal agreement between raters and measures was determined using a SDQ total difficulties cut-off score of 15 in the child-report version (Hinterding, 2011).

Training

The study team consisted of 9 local interviewers and clinical psychologists from Bielefeld University, Germany. The local team had already been extensively trained on concepts of psychological disorders with particular focus on posttraumatic stress disorder and major depression. The counsellors were proficient in the diagnostics of mental health symptoms and in the treatment of posttraumatic stress disorder. They had several years of experience in conducting clinical interviews and had been treating numerous PTSD patients with Narrative Exposure Therapy (Schauer, Neuner, & Elbert, 2011).

Before the first wave of interviews we conducted seven full days of training. Since the local interviewers already had years of experience using several of the adult screening instruments (i.e. the VWAES, the PDS, the DHSCL, the MINI, the LFS) we focused on the application of questionnaires assessing parenting behaviours and events from the family

violence spectrum in the guardian sets. A large proportion of the training was allocated to the introduction of psychological disorders and symptoms in children including attention deficit and hyperactivity disorder, conduct disorder and internalizing symptoms in children. Differences in the identification of PTSD and depression symptoms in children compared to adults were discussed. We practiced the application of the questionnaires in guided role plays and discussed pitfalls and ambiguities related to the application of the instrument. Before the second study phase we conducted another three days of training to refresh contents of the first training and to introduce the CAS and the AUDIT.

Procedure and Interviews

Antecedent to the study male and female guardians of all second grade pupils received an invitation for a parent meeting at the school via their children. At the meeting the study project was explained in detail and participants were encouraged to raise questions. After the discussion, participants gathered in small groups. The procedure of the study, risks, confidentiality and the right to withdraw without consequences were again explained within each small group by one local interviewer. Parents again had the possibility to clarify questions. If participants were interested in the interview individual appointments were made with the counsellor and informed guardian consent was obtained for the child. Participants returned to the school on the appointed days and were interviewed at a secluded place on and around the school premises. Before the interview started the interviewer explained the study to the participant again and obtained written informed consent (signature or fingerprints). All caregivers who had not been to the parent meeting were invited on an individual basis and received comprehensive explanation of the study individually. Participants did not receive any financial or material benefit for participating in the study. However, participants were given a compensation of 2000 UGX (approximately 0.90 USD) for their transport costs. Overall, only two male guardians declined participation in the study. Children were informed about the study in class. Children's interviews took place after school. Before the interview started children received a meal or a snack. When children had finished eating the interview procedure and content, risks, confidentiality and the right to withdraw without consequences were explained to each child individually and the child's written consent (signature or fingerprint) for the interview was obtained. Counsellors were instructed to approach the study co-ordinator in case questions should arise during the interview. At the end of the day all questionnaires were checked for missing items and inconsistencies

Follow-ups and Workshops

Since the subject of the study was sensitive and trauma exposure was extremely high in the current sample, we felt that we needed to take action in order to deal with the psychological as well as familial problems we encountered. As family violence was of great concern the study co-ordinator and the interviewers conducted follow-up visits to families affected by severe violence. We told participants that our visit was an offer for participants to speak out about difficulties they may experience (including poverty, land issues, stress, etc.) that could not be addressed in the interview. On the basis of the themes offered by participants suitable interventions (resource activation, psychoeducation on PTSD and alcohol, anger control techniques, etc.) and further referral options were chosen. The local therapists were accompanied or closely supervised by the first author during these home visits and received specialized training on the implementation of a manualized brief psychoeducation intervention (see Appendix 4). In case further assistance and/or monitoring were necessary or requested by the family additional steps were taken. These included activation of community support (e.g. facilitating regular visits by the village catechist) and involvement of child protection volunteers or other actors such as the LC1 in the community. Severe cases of child abuse were reported to the District Probation and Social Welfare office directly. In addition, we left contacts of NGOs that dealt with female victims of partner violence (i.e. American Refugee Committee, Warchild Canada) at the school in each community so they could be freely accessed. In case women felt it was safe for them to keep the number at home we handed out the number directly. In case of increased suicidal ideation, counsellors were explicitly instructed to immediately inform the study co-ordinator, who was always at the study site, so the person could be talked to. Suicide interventions included thorough assessment of suicidal ideation, activation of resources (i.e. family friends, and other persons), family discussion and removal of items intended to use to commit suicide, and referral for further counselling as well as follow up visits in severe cases. Regarding depression the major difficulty we encountered was a lack of accessible psychological treatment at the time of the study since group therapy for depression was only offered at Gulu Regional Referral Hospital which was too far away from the villages where the study took place. Thus, in case of severe depressive symptoms we provided psychoeducation on depression after the interview and pointed to the possibility of anti-depressive medication and psychological treatment if participants had the opportunity to go to town. Some cases could also be referred to counsellors working for World Vision in Koch Goma. Following the study, we referred cases of PTSD to our cooperation partner *(*the NGO *vivo international*) for

treatment. Twelve study participants and three cases that were identified by community members received psychotherapy for PTSD. Six more clients were referred to World Vision for treatment after obtaining release from confidentiality. However, a number of participants in the most remote villages could not be offered trauma treatment due to logistic and financial restraints.

After finishing interviews in a particular study area we offered workshops for school staff and community members from participating communities. The workshops were supposed to disseminate knowledge on the psychological consequences of war trauma, particularly PTSD. In addition, we sensitized participants towards the problem of family violence and provided knowledge and practice in basic counselling skills to encourage and enable participants to talk to vulnerable children and adults.

Statistical Analysis

Statistical analyses were chosen according to the respective hypotheses and the requirements of the data. The methods sections of the individual manuscripts contain all details on analytic and statistical procedures. Analyses were run with JMP 6.0 and JMP 11.0 software package (SAS Software, Cary, NC) and SPSS Version 21 (IBM Corp., Armonk, NY).

4 Summary of results and implications for interventions

4.1 Partner violence against women in post-conflict northern Uganda

The first manuscript targeted the prevalence and predictors of ongoing partner violence experienced by northern Ugandan women in the post-conflict period. We selected the subsample of 235 currently married or cohabiting couples from rural sites. Results showed that high levels of partner violence against women persisted although the war had been over for several years. Past-year prevalence of at least one type of abusive behaviour experienced from male partners was 86%. Physical or sexual abuse in the past year was reported by 72% of women. The vast majority of women (80%) experienced at least one act of verbal/psychological abuse in the year preceding the interview. More than half (52%) had been deliberately isolated from friends and family by their partner. About one quarter of women reported rape or attempted rape by their intimate partner in the past year. Forty-three percent of women indicated that they were currently afraid of their partners.

When we tested risk factors for female partner violence victimization and for male partner violence perpetration simultaneously in a multiple linear regression model (CAS sum-score full model's adjusted $R^2 = .23$; $F\ (17, 217) = 5.02$, $p < .01$), we found that women who had been exposed to higher levels of war-related trauma ($\beta = .24$, $p < .01$), who currently suffered from more posttraumatic re-experiencing symptoms ($\beta = .14$, $p = .03$) and whose male partners reported elevated levels of alcohol-related problems ($\beta = .14$, $p = .03$) were at an increased risk of experiencing higher levels of abuse from their intimate partner.

Multiple regression analyses on the CAS subscale sum-scores (CAS verbal/psychological abuse model's adjusted $R^2 = .10$; $F\ (17, 217) = 2.61$, $p < .01$; CAS physical abuse full model's adjusted $R^2 = .21$; $F\ (17, 217) = 4.76$, $p < .01$; CAS isolation full model's adjusted $R^2 = .22$; $F\ (17, 217) = 4.90$, $p < .01$; CAS sexual abuse full model's adjusted $R^2 = .10$; $F\ (17, 217) = 2.45$, $p < .01$) revealed that different risk factors were not equally relevant for different subtypes of partner violence: Women who reported higher levels of war-related exposure were at an increased risk to experience verbal partner violence ($\beta = .17$, $p = .04$), physical partner violence ($\beta = .24$, $p < .01$) and isolation ($\beta = .24$, $p < .01$). Long-term abduction in women was predictive of women's isolation ($\beta = .16$, $p = .03$) and sexual victimization ($\beta = .18$, $p = .01$). Women's history of childhood maltreatment was independently associated with ongoing verbal ($\beta = .16$, $p = .02$), and sexual partner abuse ($\beta = .16$, $p = .02$). Posttraumatic re-experiencing symptoms increased women's risk of experiencing physical partner violence

(β = .15, p = .02) and isolation (β = .17, p < .01). Alcohol-related symptoms in men predicted more verbal (β = .16, p = .02) and physical violence (β = .17, p < .01) against women. The differential risk patterns suggest that partner violence is not a unitary phenomenon (Hegarty, Sheehan, & Schonfeld, 1999; Johnson & Ferraro, 2000; Johnson, 1995; Johnson, 2005). Different etiological factors may underlie different sub-types of partner violence. War exposure in women emerged as the strongest predictor of the overall level of partner violence experienced by women and predicted three out of four subtypes of partner violence against women. These findings highlight the urgency of therapeutic approaches on the relationship level that consider women's previous trauma exposure (Cougle, Resnick, & Kilpatrick, 2009). Women who have been exposed to severe war atrocities over an extended period of time may be more prone to consider violence as a norm in conflict (Jewkes, Levin, & Penn-Kekana, 2002; Vinck, Pham, Stover, & Weinstein, 2007) and may have difficulties regulating their affect and modulating their anger in the face of perceived interpersonal threat (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). In this case de-escalating strategies such as emotion regulation and seeking social support for mediation may be useful. In addition, individual trauma treatment appears to be indicated when women suffer from elevated levels of posttraumatic re-experiencing symptoms. Involvement of partners through psychoeducation on trauma-related symptoms may enhance male partners' understanding and support and may assist remission.

The experience of childhood family violence predicted ongoing verbal and sexual abuse in women's current relationship. In this case, we speculate that women who learned violent relationship norms that stress a rigid relationship hierarchy under male superiority during childhood (Ehrensaft et al., 2003) may be at an increased risk of suffering from abasement and coerced sex in their intimate relationships because these women lack competencies in terms of boundary setting and assertiveness. Thus, high levels of childhood family violence may have different treatment implications (e.g. challenging a rigid relationship hierarchy, empowerment of women, assertiveness training and improving access to legal support etc.) in the case of ongoing partner abuse.

In the case of male alcohol dependence or alcohol abuse interventions such as Behavioral Couples Therapy (O'Farrell & Fals-Stewart, 2000) that target individual alcohol-related symptoms, activate spousal support and help to improve relationship functioning may be appropriate when partner violence largely emerges from conflict over male partners' drinking (Jewkes et al., 2002). Finally, evidence from qualitative studies suggests that women who return from the bush after long-term abduction are at an increased risk to be pressured

into marriages in which they occupy a low social status and are at a high risk to be stigmatized, exploited and abused. At the same time it appears to be particularly difficult for formerly abducted women to leave those abusive marriages because of patriarchal traditions and financial pressures (Annan & Brier, 2010). In order to counteract gender-based inequalities the International Federation of Human Rights recommend the adoption of training schemes by the government and the provision of trainings to actors in the justice and law sector as well as local authorities and community services officers. Awareness raising programs and improved co-operation between governmental and non-governmental institutions with regard to legal support and health care services may further contribute to a reduction in gender-based violence (International Federation of Human Rights, 2012).

In sum, it appears there is no simple or one-dimensional solution to the problem of women's victimization in intimate relationships. Nor does the phenomenon of partner violence experienced by women appear to conform to a particular type or underlying risk pattern. Individual and relationship-level approaches seem to be needed to address the complex nature of the phenomenon. We conclude that effective interventions should be carefully adjusted to the type of partner violence and individual risk factors of each partner.

4.2 Family violence against children in post-conflict northern Uganda

The second manuscript concentrated on the prediction of child maltreatment in the post-conflict period. Two different conceptual approaches were taken to elucidate the complex relationship between war-related risk factors and elevated levels of family violence against children. Firstly, we examined risk factors underlying higher levels of guardian-reported perpetration against the index child within dyadic interactions. Secondly, we applied a family system approach to predict child-reported levels of maltreatment within the family context. We used data from 365 child-female guardian dyads, 301 child-male guardian dyads and a subsample of 283 triads including the child and both female and male guardian.
We conducted separate linear regression models to identify individual predictors of more aggressive parenting in female and male guardians. All models controlled for location, the value of household assets per capita as indicator of socioeconomic status, age of guardian, age of child and sex of child. The explained variance was full model's adjusted $R^2 = .35$, F (17, 347) = 12.76, $p < .001$ in the female guardian model and full model's adjusted $R^2 = .27$, F (17, 283) = 7.79, $p < .001$ in the male guardian model. Guardians' self-reported aggressive

parenting behaviour in difficult situations with their child was most strongly predicted by parents' own aversive experiences in the home during childhood ($\beta = .41$, $p < .01$ in female guardians; $\beta = .34$, $p < .01$ in male guardians). Women's psychopathological symptom levels did not show an independent association with female guardian's self-reported aggressive parenting behaviours. In contrast, male guardians who suffered from more severe PTSD symptoms ($\beta = 15$, $p = .02$) and had more alcohol-related symptoms ($\beta = 12$, $p = .03$) reported more aggressive parenting behaviours towards their child. Women's victimization in intimate relationships predicted more self-reported perpetration against the child ($\beta = 19$, $p < .001$). Children's own traumatic experiences also increased female guardians propensity to act aggressively in difficult situations with their child ($\beta = 19$, $p < .001$). Both male and female guardians indicated that they had employed more different types of aggressive parenting behaviours when the child was their biological child ($\beta = 16$, $p < .01$ for male guardians and $\beta = 18$, $p < .001$ for female guardians, respectively).

A simultaneous analysis of risk factors in male guardians, female guardians and children with regard to the prediction of child-reported levels of maltreatment revealed that children who perceived violent interactions between guardians in the home were at a high risk to have experienced more different types of abusive behaviours themselves ($\beta = 45$, $p < .001$). Children's exposure to traumatic events unrelated to family violence also increased children's risk of experiencing violence at home ($\beta = 28$, $p < .001$). Guardian variables that additionally put children at risk were female guardians' previous exposure to childhood family violence ($\beta = 13$, $p = .02$) and war-related traumatic events ($\beta = 14$, $p = .02$). Children whose male guardians suffered from higher levels of PTSD symptoms also proved to be more vulnerable toward maltreatment in the family ($\beta = 13$, $p = .04$). The model controlled for location, value of household assets per capita as indicator of socioeconomic status, age of guardians, age of child and sex of child and had a full model's adjusted $R^2 = .37$; F (24, 258) = 7.95, $p < .001$.

In sum, these results suggest that guardians' war-related exposure increases children's risk of being maltreated. The effect may be more direct in the case of female guardians whereas PTSD symptoms may operate as a mediator between traumatic war events and child victimization in the case of male guardians. The contribution of children's own exposure to traumatic events outside the family to children's victimization within the family system highlights the fact that children are not mere recipients of family violence but actively co-construct their immediate environment. Interventions to prevent and reduce maltreatment of children should thus include all members of the family. On the relationship level, positive parenting practices may be helpful to improve the parent-child interactions by challenging

violent relationship norms and harmful practices that might have been conferred to guardians during their own childhood. Individual trauma-focused treatment may further improve the functioning of war-affected families by alleviating posttraumatic stress symptoms in guardians as well as in children and lay the foundation for more positive parent-child interactions. Violence between guardians appears to be an important mediating factor in the intergenerational transmission of violence as well as in the proliferation of war violence in the family system. Thus, in order to effectively counteract child maltreatment in the post-conflict period it appears to be imperative to address the psychological damages done by past war experiences as well as ongoing violence between adults in the family. As has been laid out above the treatment of alcohol-related problems may prove useful in this context.

4.3 Ecological and intergenerational risk assessment of child psychopathology in post-conflict northern Uganda

The third manuscript targeted the interplay of ecological and intergenerational risk factors to predict psychopathological symptoms in children in the post-conflict period. In particular, we examined child internalizing and externalizing symptoms, depression symptoms and PTSD symptoms. We investigated the independent effects of exposure to traumatic events on the community level, loss of at least one parent, the experience of family violence and child-perceived maternal care on children's psychological adjustment. We also included previous exposure to war and childhood family violence in addition to current psychopathology in female guardians to account for female guardians' influence on child adjustment. We examined a sub-sample of $N = 513$ female-guardian-child dyads for the present analyses. Multivariate linear regression modelling revealed that traumatic experiences in children predicted internalizing and externalizing behaviour problems ($\beta = .21$, $p < .01$), depression symptoms ($\beta = .14$, $p < .01$), and PTSD symptoms ($\beta = .45$, $p < .01$) in children. Increased levels of intra-familial violence were also independently associated with adverse child mental health outcomes in terms of higher symptom levels of internalizing and externalizing behaviour problems ($\beta = .24$, $p < .01$), depression ($\beta = .17$, $p < .01$), and PTSD ($\beta = .11$, $p < .05$). Perceived maternal care appeared to reduce children's risk of developing psychopathological symptoms. Good child-perceived maternal care predicted less symptoms of PTSD ($\beta = -.17$, $p < .01$), less internalizing and externalizing behaviour problems ($\beta = -.22$, $p < .01$) and lower levels of depression ($\beta = -.25$, $p < .01$). When controlling for children's

exposure levels and perceived maternal care neither maternal exposure to childhood family violence nor war violence nor current maternal psychopathology had an independent effect on children's mental health symptoms. The fit of the full model was adjusted $R^2 = .23$, $F(20,492) = 8.81$, $p < .001$ in the prediction of internalizing and externalizing symptoms; adjusted $R^2 = .19$; $F(20,492) = 6.92$, $p < .001$ in the prediction of depression symptoms; and adjusted $R^2 = .34$; $F(20,492) = 14.30$, $p < .001$ in the prediction of PTSD symptoms.

We conducted serial mediation analyses to explore the transactions of risk factors across different levels of children's socio-ecological context while controlling for inter-generational effects. The effect of children's exposure to general traumatic events was partially mediated through dysfunctional interactions within the family system and lower perceived care in children's dyadic relationship with female guardians for all types of psychopathological symptoms in children, i.e. with respect to child PTSD (*effect size* = .04, 95% Bootstrap CI [.01, .08]), internalizing and externalizing symptoms (*effect size* = .07, 95% Bootstrap CI [.02, .12]) and depression symptoms (*effect size* = .04, 95% Bootstrap CI [.02, .07]). Another one-staged mediation linked children's traumatic exposure to child internalizing and externalizing problems (*effect size* = .17, 95% Bootstrap CI [.10, .27]) and to children's depression symptoms via elevated levels of family violence (*effect size* = .07, 95% Bootstrap CI [.02, .13]).

In northern Uganda children in the post-conflict period encounter high levels of general traumatic events and family violence. Highly exposed children are at an increased risk to develop psychopathological symptoms while maternal care potentially buffers the adverse effect of violent exposure. When controlling for child variables there was no direct effect of female guardians' exposure or psychopathology on children's mental health symptoms. Results from the serial mediation models suggest an accumulation of risk across distal and proximal levels of children's environment even when controlling for female guardian variables. The partial mediation points to a re-victimization process in trauma-exposed children through dysfunctional dyadic and polyadic interactions (Rutter, 1985). The current findings suggest that family interventions tailored to reduce inter-parental and parent-to-child violent behaviour may be highly effective in reducing children's psychological symptoms and promoting children's healthy development in a post-conflict context. Based on the results of our mediation analyses we conclude that family-level interventions may have a great potential to benefit children who suffer from depressive and more general emotional and behavioural symptoms. A previous randomized controlled trial involving northern Ugandan children and youth pointed to the limited effectiveness of Interpersonal Therapy (IPT) in reducing child

depression, anxiety and conduct problems (Bolton et al., 2007). These findings highlight the need to systematically evaluate family interventions as a potential treatment alternative for children with elevated depression symptoms or increased internalizing and externalizing symptoms. Given the comparatively lesser mediation via family and relationship variables in the prediction of posttraumatic stress symptoms we conclude that severely traumatized children are likely to require additional trauma-focused therapy (Ertl, Pfeiffer, Schauer, Elbert, & Neuner, 2011; Salloum & Overstreet, 2012). Considering that perceived maternal care mitigated the adverse effect of family violence in all three serial mediation models, conferring positive parenting practices may benefit child psychological adjustment (Gewirtz et al., 2008) across clinical syndromes. In situations where female guardians and children have both been victims of domestic violence or share the same war-related trauma (e.g. grandmother and child witnessing the murder of the daughter/mother) relationship-focused psychotherapy that helps to create a joint narrative of traumatic events (Lieberman, Van Horn, & Ippen, 2005) may be preferred over parenting training or individual psychotherapy alone in order to alleviate child psychological distress and promote children's healthy development. Taken together the present findings demonstrate the need for differential provision of treatment based on diagnosis and symptom severity. Screening procedures that can be employed by teachers, school counsellors, community health workers or other community level actors may help to identify children in need of treatment. Specially trained health care providers may establish sound diagnoses and match cases to targeted psychological interventions.

5 Resume and perspective

The present study was the first study that included male and female guardians as well as children in order to examine the interplay of intergenerational and ecological risk factors in the prediction of family violence and child mental health in a post-conflict setting. We employed different levels of analysis, namely the individual, the family, and the dyadic relationship level. The study demonstrated that it is feasible and highly relevant to address the issue of protracted family violence and its effects on children's mental health in post-conflict societies.

Implications of the study and prospects

High levels of ongoing partner violence against women in northern Uganda point to the need for effective programs that address the problem of alcohol abuse in male partners and are sensitive to previous violent and traumatic experiences in women. As partner violence does not seem to be a unitary phenomenon service providers may pay close attention to the contextual conditions and the underlying risk patterns in individual cases. The prevention and reduction of partner violence against women in northern Uganda is an integral component of rebuilding nonviolent economic, social, and moral structures that provide the basis for long-lasting peace and the healthy development of children in the post-conflict period.

As war-related violence appears to contribute to family violence against children, particular effort should be made to protect children in post-conflict settings. High rates of family violence against children in northern Uganda highlight the need for more effective programs. In the past decade improvements in child protection in Uganda comprised a legal basis for child protection (i.e. the children's right act), the integration of child protection in the educational system as part of the social work curriculum at several universities (Uganda ministry of gender, labour and social development, TPO, Oak Foundation, & Unicef, n.d.), the formulation of a child protection recovery strategy for northern Uganda (Uganda ministry of gender, labour and social development, 2009) and the establishment of a referral structure with agents on the community level (i.e. child protection volunteers), on the sub-county level (i.e. community development officers), and within the executive forces (i.e. formation of child protection units within the police force). However, the effectiveness of referral remains low. A study in a central district in Uganda revealed that only a small proportion of children (3.8%) referred for maltreatment received an adequate response (Child, Naker, Horton, Walakira, & Devries, 2014). The authors concluded that despite the existence of the referral

structure the response to children's disclosure of abuse was insufficient. Findings from the present work suggest that screening for vulnerability factors such as PTSD and alcohol-related problems in parents and high levels of inter-parental violence may be expedient for the early identification and prevention of child maltreatment in high-risk families. Complementary treatment components such as psychotherapy for PTSD and alcohol-related problems and relationship-focused interventions may also help to improve existing programmes. Installing additional treatment components implies that there are additional training needs: Community workers need to be trained to screen for specific risk constellations (e.g. high levels of alcohol-related problems, high levels of partner violence, PTSD in male guardians, high levels of trauma exposure in female guardians). Specialized mental health workers and therapists may treat psychological disorders such as PTSD and substance dependence and, as a secondary outcome, may help to improve family functioning. Family therapists and trained counsellors may provide non-violent means of communication and conflict resolution to reduce inter-parental violence. In addition, they may provide non-violent means of educating and disciplining children. Since the current study is one of the few studies in northern Uganda that addresses family violence against children in a two-generational design, more research is needed to substantiate the present findings, to identify additional vulnerability factors and to determine additional treatment needs. The implementation of effective programmes relies on a careful coordination of agents in the field. Future research is needed because the documentation and the sound evaluation of the efficacy of such programmes are essential (Eisenbruch, de Jong, & van De Put, 2004).

The present study shows that psychopathological symptoms in children increase when elevated levels of family violence combine with high exposure to traumatic events in the community context and less perceived care in children's proximal environment. These findings support the argument for multi-levelled intervention programmes in post-conflict settings (Betancourt, Meyers-ohki, Charrow, & Tol, 2013). For the prevention of maladjustment in children, structural community-based approaches may be beneficial in reducing children's exposure to adversity in general. Family-based interventions that target intra-familial violence appear crucial, for family violence being one of the major threats to children's healthy development. Parent-focused interventions may be effective in promoting resilience in children as more responsive and caring parents seem to buffer the deleterious impact of environmental stressors on child mental health. In addition, the current research suggests that successful treatment of the individual child depends on a careful match between the child's condition and the type of treatment provided. In addition, transactions between

children's characteristics (e.g. developmental stage, type of symptoms) and characteristics of the child's proximal environment (e.g. parents' mental health) may strongly influence adaptive functioning of the child (Cicchetti, 2013). Attachment theory provides a useful framework for the analysis of transactions between children's psychopathological symptoms and parents' responses. According to this model dysfunctional attachment-related processes on different levels (individual, interpersonal and meta-cognitive) foster symptomatic cycles in which children's symptoms and indirect communication reinforce parents' negative appraisal and sense of failure and vice versa. At the core, attachment-based interventions aim to alter the child's and the parent's internal working model of each other to develop the parent's capacities for empathy and reflective functioning with the child and the child's confidence in the parent's availability (Atkinson & Goldberg, 2003). Future research may evaluate the effectiveness of such relationship-focused interventions in northern Uganda. In order to successfully implement mental health services in resource-poor countries Belkin et al. (2011) proposed a planning framework that organizes mental health service provision into different skill sets on which to build a range of care pathways. According to Silove (2004) the role of mental health professionals in post-conflict settings should focus on the treatment of those who face the greatest adaptive risk. Considering the rates of 0.09 psychiatrists and 0.02 psychologists per 100,000 citizens in Uganda (World Health Organization Department of Mental Health and Substance Abuse, 2012) it becomes apparent that these care pathways need to be infused with clinical knowledge that is evidence-based and locally relevant. The current research was able to produce some first insight in the treatment needs of war-affected northern Ugandan families and children growing up in the post-conflict period. However, more research is needed to examine the effect of risk factors on different levels over time and to identify interactions and bidirectional processes.

Limitations

Despite the merit of including a large sample with respondents from two generations in the context of a post-conflict setting, the present study suffers from a number of limitations. Recruitment of participants did not follow a random sampling procedure, which means that results may not be easily translated to other populations. With the exception of the SDQ none of the instruments used to assess child mental health symptoms in the current study have been validated. In addition, children in the study were still young and may have lacked the full capability to reflect on their mental health symptoms. Cross-sectional designs inherently fail to provide evidence of causal relationships. Bidirectional effects between parent and child

behaviour have been largely neglected in the current study. Report bias constitutes another shortcoming of cross-sectional data, particularly concerning retrospective reports. And finally, the study was almost exclusively based on self-report data that was assessed using standardized questionnaires in an interview format. In the manuscripts presented in the cumulative dissertation we focused on the interplay of risk factors within the family context but largely neglected the school context.

Additional works and further developments

Beyond the manuscripts that are presented in this thesis the research project has produced several studies that addressed some of the limitations mentioned above. For example, a large proportion of children from the current study were followed up in 2012 to trace developmental trajectories over time. Other works focused on different components in the proposed conceptual model and elaborated on some of the findings that were discussed above.

Perceptions of child psychopathology: The assessment of psychopathological symptoms in children by different raters and the meaning of inter-rater discrepancies

Obtaining data from different sources to assess psychopathological symptoms in children can help to improve the overall validity of the data. The optimal use of data from multiple informants and the handling of discrepant data remain challenges in the clinical assessment of child psychopathology. At the same time a better understanding of discrepancies between informants may help to better understand the causes of maladjustment in children and may yield important treatment implications (Achenbach, 2006). Using data from the present sample, two studies focused on the assessment of child mental health symptoms in the northern Ugandan context and evaluated the agreement between different informants. The first study that has already been described in the method section provided evidence on the validity of the Luo version of the SDQ in northern Ugandan second grade children although agreement with the CBCL rating was rather low (Hinterding, 2011). Future studies may consider structured diagnostic interviews as a gold standard in order to provide further evidence on the validity of screening instruments in the assessment of psychopathological symptoms in northern Ugandan children.

The second study investigated inter-rater agreement and discrepancies regarding children's internalizing and externalizing symptoms when using the parent-report form, the teacher-report form and the self-report form of the Strengths and Difficulties Questionnaire in

parallel. Besides clinical interviews the integration of ratings from multiple informants is commonly held as the gold standard in the diagnostics of child psychopathology. While researchers often find low to moderate agreement between parents' and children's ratings (Achenbach, 2006; De los Reyes, Alfano, & Beidel, 2012) to date little is known about the inter-rater agreement on child emotional and behavioural symptoms in post-conflict settings. Jeanneret (2013) examined the agreement and factors associated with discrepancies between parents' ratings, teachers' ratings and children's ratings of child internalizing and externalizing symptoms as assessed by the SDQ in the present sample. In general the correlations between female guardians' ratings, male guardians' ratings, teachers' ratings and children's ratings were non-significant. Weak positive correlations were found between female guardians' ratings and children's ratings of emotional symptoms (Spearman's rho ρ = .09, $p < .05$), between teachers' ratings and children's ratings of hyperactivity symptoms (Spearman's rho $\rho = .12$, $p < .01$), and between female guardians' ratings and male guardians' ratings of child conduct problems (Spearman's rho $\rho = .12$, $p < .05$). Teachers and male guardians appeared to be more similar in their perceptions of child symptoms than teachers and female guardians. In previous studies discrepancies between parents' and children's ratings predicted a range of adverse child outcomes in terms of anxiety symptoms, emotional and behavioural problems, deliberate self-harm, police and judicial contacts, expulsion from school, unwanted pregnancy and drug and alcohol use (De los Reyes et al., 2012; Ferdinand, van der Ende, & Verhulst, 2004). Regarding the low levels of agreement in the present study Jeanneret (2013) conducted an analysis of the independent risk factors that were associated with higher discrepancies in ratings between guardians and children. When controlling for a number of family variables (family SES, number of children in the household), relationship variables (perceived maternal care, time spent with mother) and individual variables in children (age, gender, the level of exposure to general traumatic events, the level of exposure to family violence) and individual variables in female guardians (age, depression symptoms, PTSD symptoms, the level of traumatic exposure, the level of exposure to childhood family violence), more depressive symptoms in female guardians and more family violence experienced by female guardians in childhood emerged as independent risk factors of higher discrepancy scores. As female guardians tended to rate children's symptoms higher than children themselves, these findings suggest that maltreated and depressed female guardians perceive their children's behaviour as more problematic. Following the epidemiological survey we conducted a pilot treatment study that comprised eight traumatized female guardians who received Narrative Exposure Therapy for Posttraumatic Stress Disorder. We

assessed participants at baseline (3 to 12 months pre-treatment), at the beginning of the therapy and six-months after the therapy had ended. Parallel trends emerged in symptom severity levels and female guardians' perception of child behaviour. When comparing children's and female guardians' ratings we found that female guardians' perception of children's behavioural problems were much higher than children's self-reported symptoms over the year before psychotherapy but significantly reduced in the months following treatment. It appeared that mothers' ratings approximated children's ratings after therapy, although the conclusion is hampered by the fact that children could not be assessed at the last follow-up (Ertl, Saile, Neuner, & Catani, 2014). When entering female guardians' perception of children's emotional and behavioural difficulties in the model predicting harsh parental behaviours (see manuscript 2), a significant proportion of variance in parental aggression towards the child is explained by female guardians' ratings of child symptoms ($\beta = 23$, $p < .001$; adjusted $R^2 = .39$; $F\ (18, 346) = 13.92$, $p < .001$). At the same time the proportion of variance explained by female guardians' exposure to childhood maltreatment is reduced ($\beta = 41$, $p < .001$ in the original model versus $\beta = 34$, $p < .001$ in the model including female guardians' SDQ total difficulties rating). These results suggest that the relationship between maternal exposure to childhood family violence and their proneness to employ aggressive parenting strategies towards their child may partially be mediated by a bias toward perceiving child behaviour as more problematic. It has been shown that maltreatment in childhood affects social information processing with respect to reduced attentiveness to relevant social cues, a pronounced bias toward attributing hostile intent and less competencies in generating (non-violent) solutions to interpersonal problems (Dodge, Bates, & Peitit, 1989). All these processes may play a role in the intergenerational transmission of aggressive parenting in the female guardians studied. The present findings indicate that successful psychotherapeutic interventions that aim at the reduction of psychopathological symptoms may, as a secondary outcome, be accompanied by a reduced bias toward perceiving child behaviour as problematic. This might be particularly true for interventions such as Narrative Exposure Therapy that aim at a reprocessing and biographical integration of maltreatment experiences in childhood in addition to other traumatic events. Moreover, parenting interventions that directly target attentiveness, appreciation and competent (non-violent) parenting behaviours toward the child may be useful to foster more positive parent-child interactions and interrupt the intergenerational cycle of abuse. More research is definitely needed to elucidate the mediating mechanisms between parental victimization, alterations in emotion and cognition and aggressive behaviour towards children in northern Uganda.

Focus on parenting: Direct behaviour observation of parent-child interactions and parenting training in northern Uganda

In order to gain more in-depth knowledge on parent-child interactions that are associated with more aggressive parenting behaviours towards the child, Wieling and colleagues from the department of Family Social Science at the University of Minnesota piloted direct behaviour observations of mother-child interactions in structured interaction tasks in a subsample of $N = 18$ dyads from the epidemiological study. Möllerherm and colleagues (2013) further developed the structured interaction tasks to include culturally adapted verbal and non-verbal tasks. She collected data from an additional 106 mother-child dyads and adapted the family and peer process code manual (Stubbs, Crosby, Forgatch, & Capaldi, 1998) to fit the northern Ugandan context. The data from this ongoing project will make a substantial contribution to the understanding of dysfunctional interactions between mothers and their children and give valuable insights for the development of targeted parenting interventions.

In order to test the feasibility of parenting programs in the northern Ugandan context, Wieling and colleagues conducted a pilot intervention with two parallel groups of 15 mothers using an adapted version of the Parent Management Training – Oregon Model (PMTO) (Forgatch & DeGarmo, 1999) in 2012. The intervention was welcomed by participants and yielded positive responses in terms of utility (Wieling, Mehus, Moellerherm, Catani, & Neuner, 2013). Direct behaviour observation was employed pre- and post-treatment and at a 6-month-follow-up interval in order to obtain an objective measure of change in mother-child interactions.

Focus on alcohol abuse: The prevalence and risk factors of alcohol-related symptoms in men

Further developments from the present work comprised subsequent analyses of the prevalence and predictors of alcohol-related problems experienced by men. In the studies presented in this thesis, male guardians' alcohol-related problems were a consistent risk factor in the prediction of ongoing partner violence against women and men's aggressive parenting behaviours against children. A previous study in northern Uganda suggested that 32% of men in IDP camps had elevated levels of alcohol-related symptoms and that hazardous drinking was associated with higher levels of war-related traumatic events and an older age (Roberts et al., 2011). In the present sample we found a prevalence rate of 46% hazardous drinking in male participants. In order to explore potential contributing factors underlying higher levels of

alcohol-related symptoms, we employed a linear regression model that included demographic variables (men's age and education, location, estimated value of household possessions and number of children), men's level of exposure to family violence during childhood, men's level of war-related exposure as well as men's depression and PTSD symptom severity (adjusted $R^2 = .12$, $F\ (14, 286) = 4.21$, $p < .001$). Men who had experienced higher levels of family violence during childhood ($\beta = .14$, $p = .03$) and had higher levels of PTSD symptoms ($\beta = .14$, $p = .05$) were at a higher risk of having more alcohol-related problems. Higher depression symptoms were independently associated with less alcohol consumption and alcohol-related symptoms in men ($\beta = -.23$, $p < .01$) as assessed by the AUDIT (Saile, Neuner, Ertl, & Catani, 2013). These findings suggest that there is a relationship between previous traumatic exposure, ongoing psychopathology and alcohol abuse in northern Ugandan men, but that the relationship may be rather complex. More research is needed that includes other potential mediators and a more differential assessment of drinking patterns. Experience sampling methods may be useful to gain in-depth knowledge about drinking patterns. Other means of assessing the relationship between posttraumatic psychopathological symptoms and reactions to alcohol-related cues might also be interesting in this context. For example, experimental designs that provoke craving (e.g. measured by the amount of secreted saliva) and anxiety through exposure to trauma-related cues, alcohol-related cues and neutral context (Sinha et al., 2011) could be adapted to substantiate posttraumatic stress disorder as a risk factor for alcohol abuse and dependence in post-conflict northern Uganda. Randomized controlled treatment trials could be used in a pre-post design to test the efficacy of trauma-focused treatment in reducing alcohol craving and distress in response to trauma-related as well as alcohol-related cues (Coffey, Stasiewicz, Hughes, & Brimo, 2006). In the long term alcohol-related disorders appear to be associated with higher suicidality (Kizza, Hjelmeland, Kinyanda, & Knizek, 2012), more family violence (Saile et al., 2013, 2014), and reduced economic and social functioning (World Health Organisation, 2010). In northern Uganda, treatment options for affected individuals are scarce to virtually non-existent. The only treatment program available combines group interventions for alcohol dependent men in combination with economic support to spouses and relatives (Mwaka, 2013). A successive research project proposed by Ertl and colleagues aims to examine alcohol-dependent men who participate in the program and their families in terms of alcohol consumption, traumatic experiences in childhood and during the war, psychopathology, domestic violence, emotion regulation and daily functioning in a pre- post- follow-up design. A comparison between treatment groups with versus without a microcredit component is planned to assess the

additional effects of microcredits in terms of individual and family level outcomes. In cooperation with colleagues from the department of Family Social Science at the University of Minnesota a more in-depth examination of the effect of alcohol-related disorders and their treatment on family functioning is planned.

The school context: Peer reputation and school violence

Apart from family functioning we also examined children's experiences and their behaviour in the school context. Two additional manuscripts examined the assessment of peer reputation in northern Ugandan school children (Möllerherm, 2012) and the prevalence and predictors of school violence experienced by children in the present sample (Steffmann, 2013). Möllerherm (2012) conducted an in-depth analysis of the factor structure of the shortened version of the Revised Class Play (RCP) and the relationship between the RCP sub-scales and children's self-report of psychological adjustment in the northern Ugandan sample. Möllerherm (2012) concluded that the shortened version of the RCP resembled the 3-factor structure of the original scale. However, the author pointed out that the dimensions described slightly different constructs in Ugandan children compared to the original US sample. One factor described aggressive and sensitive behaviour (*Aggressive-sensitive* instead of *Aggressive-disruptive*). The author argued that the factor *Sociability-leader* assessed socially active and sociable behaviour without necessarily describing prosocial behaviour. The last factor (*Isolated* instead of *Sensitive-isolated*) captured voluntary and involuntary isolation from peers without the implication of depressive or anxious affect. Overall, children's self-reports of psychological symptoms and peer problems did not correlate with peer reputation. When using the original items on the three RCP scales, we found marginally positive correlations between teachers' perceptions of child conduct problems and peer ratings on aggressive-disruptive behaviours ($\rho = .09$, $p = .09$) and between teachers' reports of prosocial behaviour and higher scores on the scale *Sociability-leadership* as rated by peers ($\rho = .10$, $p = .07$). A negative (but non-significant) correlation was found between teachers' ratings of peer problems and children receiving higher ratings on the *Sociability-leadership* scale ($\rho = -.10$, $p = .08$). Children who had been exposed to more traumatic events ($\rho = .15$, $p < .01$), who experienced more family violence ($\rho = .10$, $p = .06$), and who perceived their female caregiver as less caring ($\rho = -.11$, $p = .04$) were rated higher on the *Aggressive-disruptive* scale by their peers. Using multiple regression analyses, Möllerherm (2012) found that orphans and traumatized children were rated as more aggressive and sensitive by their peers. In summary, we conclude that more research is needed to improve on the validity of instruments assessing

emotional and social behaviour problems as perceived by peers in northern Uganda. It appears promising to compare local syndromes of socially deviant behaviour and distress that have been identified using qualitative research methods (Betancourt, Speelman, Onyango, & Bolton, 2009) to western concepts of emotional and behavioural problems in children in an "etic-emic integrated approach" (Rasmussen, Smith, & Keller, 2007). The inclusion of local perceptions of deviant behaviours and emotional problems (e. g. as described by Betancourt et al., 2009) may help to improve sensitivity of instruments assessing emotional symptoms and social behaviour in northern Uganda by including culturally relevant symptoms that can be recognized by peers. Western constructs of emotional and behavioural disorders may enhance specificity by providing a theoretical framework and empirical knowledge that helps to organize symptoms in clearly distinguishable types of disorders or syndromes. A better understanding of child adjustment in the peer context may help to prevent the rejection and re-victimization of maltreated and traumatized children in the peer context (Rogosch & Cicchetti, 1994; Zielinski & Bradshaw, 2006). Activating social support and acceptance by peers in the classroom may be useful in fostering resilience in maltreated and traumatized children (Betancourt & Khan, 2009). At the same time individual treatment of traumatized children and the improvement of emotion regulation skills (Alink, Cicchetti, Kim, & Rogosch, 2012) may help to improve peer acceptance.

As has been described in the introduction section, corporal punishment by teachers and class prefects remains a common practice in Ugandan schools (African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN) Uganda, 2011). In line with this observation, in the present study we found that 62% of children had been beaten with a stick or some other hard object at school. Children also reported that they had been slapped on the body, arms or legs (18%), that they had been punched or kicked on the body, arms or legs (11%) and that their arms had been twisted or they have been pulled by the hair (8%). Children indicated that they had been shouted at (20%), threatened (20%), ignored (8%) or ridiculed (6%) by their teacher. Sexual abuse was less frequently reported (1%) compared to other studies (4% in the ANPPCAN study), which might be explained by the relatively young age of the current sample. Steffmann (2013) investigated which children were vulnerable to be victimized at school. In multiple regression analysis, children who reported higher levels of maltreatment at home and children who described themselves as more hyperactive were more likely to be victimized at school. Unlike previous reports (ANPPCAN Uganda, 2011) boys were more likely to be maltreated by teachers or class prefects at school than girls in the current study. Steffmann (2013) found that the relationship between

maltreatment experiences at home and violent experiences at school was partly mediated by higher levels of emotional and behavioural symptoms in children as measured by the SDQ. As maltreatment in the family was a strong predictor of violent experiences at school we conclude that providing alternatives to corporal punishment and positive discipline strategies to school staff is necessary to protect children in the school context (Naker & Sekitoleko, 2009) but it is not sufficient. In order to recognize children who suffer from maltreatment at home, teachers should be trained to recognize children who display elevated symptom levels and they should be enabled to talk to affected children in a proficient and empathetic manner. Children who suffer from violence at home should receive multi-modal support as outlined above. Parents need to be involved and the family should be referred to specially trained counsellors who can assess treatment needs and refer to the respective agents for treatment.

Conclusion

The present research project produced a comprehensive picture about the challenges children and their caregivers face as individuals, as intimate partners and as families in post-conflict northern Uganda. Despite the complexities involved in researching the transmission of violence in a post-conflict setting, the current research project proved that the issue of family violence is not unspeakable of and that it is not a burden affected families have to carry on as a "family matter". Results from the study contributed to a better understanding of the risk factors that contribute to violence within war-affected families and that adversely affect child mental health. We suggested some potentially useful modules that may be integrated in larger programmes so that referral structures and intervention programmes become more effective. Clinical research on treatment needs and treatment effectiveness is highly relevant to bolster referral structures and improve care pathways. By confronting the reality of ongoing violence in war-affected families clinical research can help to protect children and to pave the way for sincere reconciliation. The healing of relationships and ongoing efforts to support to children in the post-conflict period are important steps on the way to peace in northern Uganda.

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Gedruckt auf alterungsbeständigem Papier °° ISO 9706