INTEGRATING STRATEGIES TO STRENGTHEN MENTAL HEALTH WITHIN INTIMATE PARTNER VIOLENCE PREVENTION CURRICULA

OVERVIEW

Poor mental health is both a key risk factor for intimate partner violence (IPV) and one of its most devastating consequences. Yet, while facilitated, group-based reflection and learning sessions are among the most common and effective approaches to preventing IPV in the Global South, few IPV prevention curricula intentionally address poor mental health.

The Prevention Collaborative's review of 55 IPV prevention curricula from programmes in 23 countries found that, while many acknowledge the mental health consequences of violence, only a small number explicitly integrate approaches designed to strengthen participants' mental health. Interestingly, evaluations of several curricula included in the review demonstrated positive impacts on mental health even without specific content on the topic. Whether these improvements reflect the therapeutic quality of the group process, reductions in violence, or both remains unclear.

This gap represents a missed opportunity. **Integrating evidence-based mental health strategies into existing IPV prevention curricula has the potential to enhance the magnitude, cost-effectiveness, and sustainability of programme outcomes.**

This brief aims to help practitioners seize that opportunity. Drawing on the curriculum review and on interviews with seven mental health experts, it offers a 'menu of inspiration'—concrete strategies and curriculum examples that can be adapted and integrated into existing group-based programmes. The approaches covered in the curriculum review include:

- Cognitive behavioural therapy (CBT) techniques
- Somatic practices
- Relaxation techniques and stress management
- Trauma awareness
- Peer support and co-counselling

To ground these approaches in implementation experience, the brief also draws on conversations with practitioners who have delivered the featured curricula. Their reflections appear throughout as ***Voices from Practice***. Where rigorous evaluations of the discussed curricula exist, we summarise the available evidence of their impacts on both IPV and mental health outcomes. Importantly, these evaluation findings reflect the cumulative impact of the entire curriculum rather than the effects of the standalone mental health sessions or activities described in this brief. In many cases, such evidence remains limited, pointing to an important gap in the field.

There is also an urgent need to develop and test new integrated content by drawing on the wealth of evidence from specialised mental health programmes and violence against children (VAC) prevention curricula, as the curriculum review focused specifically on IPV. The Prevention Collaborative's review of how poor parental and caregiver mental health increases the risk of child maltreatment found ample examples of VAC prevention curricula that include content designed to strengthen the mental health of parents and caregivers. This established practice makes VAC curricula a valuable source of learning for IPV prevention practitioners.

A NOTE ON THE SCOPE OF THIS BRIEF

Common mental health problems, including depression, anxiety, and trauma-related symptoms such as post-traumatic stress disorder (PTSD), are extremely prevalent globally and are the focus of this brief.[1] More complex mental health conditions, such as schizophrenia and bipolar disorder, require more specialised and comprehensive strategies and fall outside the scope of this brief.

Evidence-based strategies to strengthen mental health extend well beyond what can be integrated into group-based curricula, spanning individual, relational, community, and structural interventions. This brief focuses specifically on approaches that are suitable for adaptation by lay facilitators within a group-based curriculum.

ASSOCIATION BETWEEN INTIMATE PARTNER VIOLENCE AND COMMON MENTAL HEALTH PROBLEMS

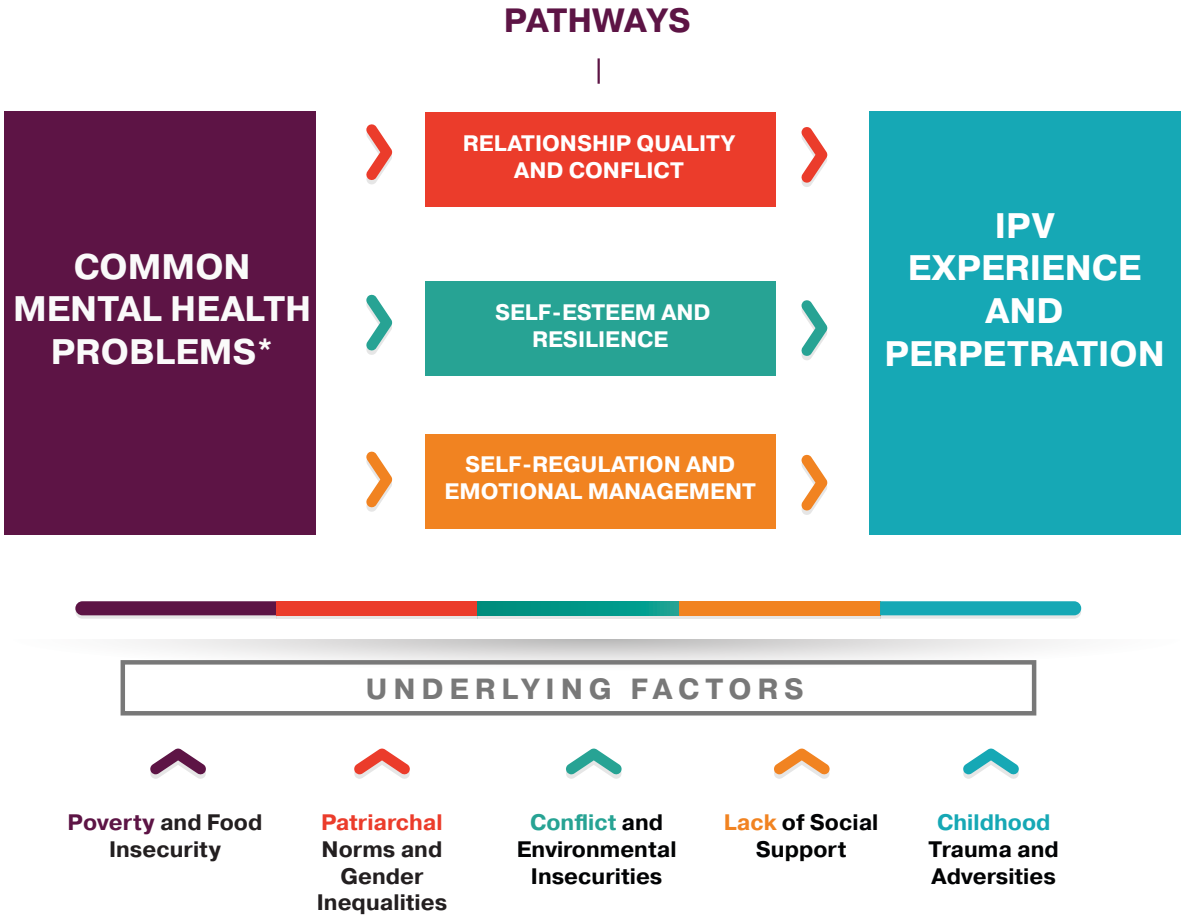
Strong and consistent evidence demonstrates that poor mental health is a significant risk factor for IPV. Strengthening mental health can therefore both support recovery and healing for survivors and serve as a primary prevention strategy.

Understanding how poor mental health increases the risk of both experiencing and perpetrating IPV can help identify the most effective points for intervention. The Prevention Collaborative's evidence review on mental health and IPV identifies three primary pathways:

RELATIONSHIP QUALITY AND CONFLICT	Common mental health problems, such as depression, can make it harder to manage disagreements, handle conflict triggers, and leave abusive relationships. Symptoms of depression can reduce relationship satisfaction and intimacy while also causing cognitive distortions (biases in thinking) that make abusive behaviour more difficult to recognise. Trauma can also lead to feelings of shame, guilt, and self-blame, which can lead to difficulties with trust and intimacy.
SELF-ESTEEM AND RESILIENCE	Trauma and mental distress can erode self-worth, sometimes leading people to believe they deserve mistreatment or preventing them from recognising it as abuse. Lower self-esteem can also make people more likely to interpret ambiguous social cues as threats, increasing the risk of reactive violence.
SELF-REGULATION AND EMOTIONAL MANAGEMENT	Traumatic experiences and common mental health problems frequently disrupt emotional regulation processes. Symptoms commonly associated with poor mental health—including anger, hostility, irritability, and agitation—are recognised risk factors for the perpetration of violence. Poor mental health can also reinforce risky coping strategies such as substance use, which in turn heightens the risk of both exposure to and perpetration of IPV.

These pathways are shaped by structural factors that contribute to poor mental health, many of which are also drivers of IPV (see Figure 1). Patriarchal norms and gender inequalities, for example, create distinct mental health risks across genders. Women in low- and middle-income countries (LMICs) face elevated rates of depression and anxiety, driven in part by a higher exposure to violence. Conversely, dominant masculine norms often discourage men from seeking mental health support. These risks further intersect with other forms of marginalisation, deepening vulnerability for specific groups. Effective mental health interventions must therefore be gender-responsive, addressing the unique barriers and risks facing women and men while remaining attentive to how these intersect with wider inequalities.

Figure 1. Pathways between common mental health problems and intimate partner violence.



***Common mental health problems include: depression, anxiety, trauma-related symptoms and post-traumatic stress disorder.**

EXPERT INTERVIEW FINDINGS

To complement the curriculum review, the Prevention Collaborative conducted interviews with seven global experts involved in developing or evaluating mental health strategies. These consultations explored the current state of knowledge in the mental health field, the mechanisms that make interventions effective, and practical lessons applicable to group-based violence prevention programmes.

Experts identified several core components suitable for integration into violence prevention curricula, including:

- Psychoeducation on mental health challenges and strategies.
- Opportunities for sharing and peer connection.
- Skills-building in coping, self-regulation, and stress management.

Experts also highlighted the importance of complementary approaches that address the shared root causes of both IPV and poor mental health, such as economic empowerment and livelihood activities.

THREE PRIORITY RECOMMENDATIONS FROM EXPERT INTERVIEWS

1. **Build Emotional Awareness and Coping Skills**
   Incorporate a strong emphasis on emotional awareness and overall wellbeing within curricula, including a clear understanding of how emotions are experienced in the body, how they influence responses to situations and events, and how coping strategies can help regulate the impact of negative emotions on behaviour. Encouraging participants to name and express their emotions, and to reflect on how they manage them (including through alcohol use), is a critical component of violence prevention, particularly when working with men and boys. Curricula should explicitly address poor mental health and stress as key risk factors for violence, rather than treating them solely as consequences of abuse.

2. **Integrate Evidence-Based Mental Health Approaches**
   Integrate strategies derived from effective therapeutic approaches such as problem-solving therapy, CBT, and Interpersonal Therapy (IPT) into group-based violence prevention programming. For example, one of IPT's core focus areas is resolving disputes with intimate partners, content that could be adapted for couples-based curricula. Similarly, CBT's emphasis on recognising and reframing conflict triggers can help couples handle conflict more constructively and reduce the risk of conflict escalating into violence.

3. **Incorporate Psychoeducation**
   Curricula should provide clear information on mental health challenges, symptoms, and practical management strategies. To ensure relevance, these topics can be identified collaboratively with group members based on their lived experiences. For instance, alcohol use may emerge as a priority issue, creating an opportunity to help participants understand how harmful alcohol use contributes to mental health problems and escalates conflict. Everyday topics, such as sleep hygiene and physical exercise, are often overlooked but highly relevant to emotional regulation and mental health wellbeing.

MENTAL HEALTH CONTENT IN IPV PREVENTION CURRICULA

The curriculum review identified different types of content designed to strengthen mental health across existing IPV prevention curricula. Each approach is described below, alongside a detailed curriculum example. Across the reviewed curricula, mental health content is typically introduced after foundational sessions have established trust, group cohesion, and shared norms. This sequencing allows facilitators to create a safe environment before exploring more sensitive topics.

APPROACH ONE: COGNITIVE BEHAVIOURAL THERAPY (CBT) TECHNIQUES

CBT-based content helps participants understand the connections between thoughts, feelings, and behaviours and develop skills to recognise and shift unhelpful thinking patterns. This is especially relevant for managing conflict triggers and reducing the risk of violence. Core elements for integration include:

- Psychoeducation on the "thinking-feeling-doing" loop.
- Exercises that help to identify and reframe unhelpful thoughts in common conflict scenarios.
- Emotional intensity scales to track and manage intense feelings.

Curriculum Spotlight: The Indashyikirwa Couples Curriculum — Rwanda
The Indashyikirwa Couples Curriculum—originally piloted and implemented by CARE Rwanda and the Rwanda Men's Resource Centre (RWAMREC) with cohabiting or married couples in rural Rwanda—draws on CBT content. This includes a dedicated **"Thinking Triangle"** (Figure 2) session that helps participants build skills to manage conflict in their own relationships.

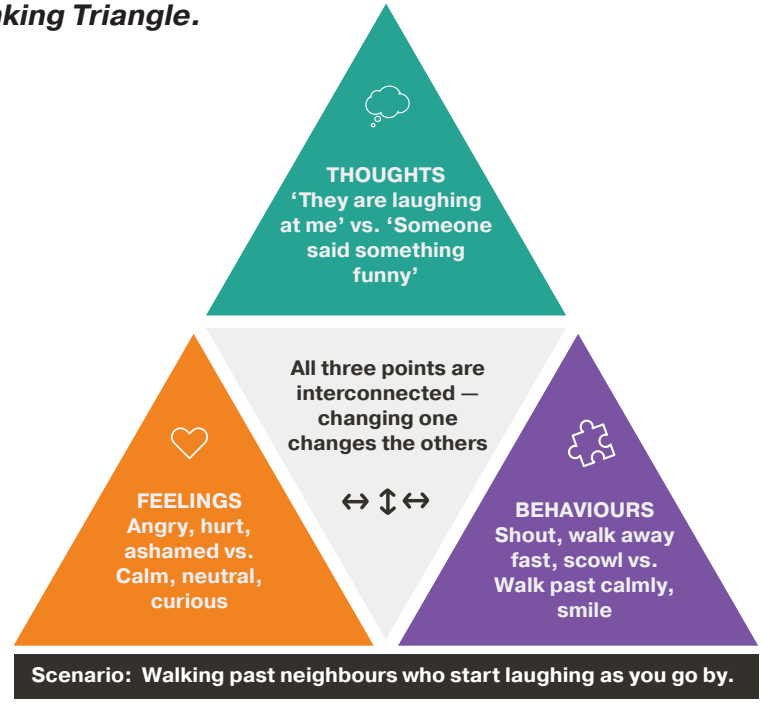
The Thinking Triangle
Before introducing the triangle, participants attend a one-hour session entitled Managing our Feelings, where they learn to recognise the intensity of their feelings using a locally grounded money scale. For example, 300 Rwandan Francs (RWF) represents mild distress, 30,000 RWF represents moderate distress, and 300,000 RWF represents intense anger. This provides a tangible measure for the "Feeling" Corner of the triangle, helping participants see that while they cannot always prevent a feeling from arising, they can use coping strategies to reduce its intensity.

The 2-hour 30-minute Thinking Triangle session introduces the core CBT insight: thoughts, feelings, and behaviours are interconnected, and changing how we think about a situation affects both how we feel and what we do. The model is made tangible through a participatory activity using a ball of string. As a scenario is read—for example, walking past a group of neighbours who start to laugh—the facilitator invites volunteers to physically map the reaction:

- **The Thought:** The first volunteer states their initial unhelpful thought ('They are laughing at me') and passes the ball of string to the second volunteer.
- **The Feeling:** The second volunteer identifies the resulting feeling and its intensity using the money scale ('I feel angry and sad—30,000 RWF').
- **The Behaviour:** The string is passed to the third volunteer to identify the resulting action ('I walk away quickly, scowl, and shout').

The physical triangle formed by the string allows the group to see how "pulling" on one point (the thought) inevitably moves the others. The activity is then repeated with a helpful alternative thought ('They must have heard a joke'), visibly demonstrating how a shift in interpretation changes the feeling (from hurt to neutral or curious) and the behaviour (walking past calmly rather than reacting).

Figure 2. The Thinking Triangle.



Participants then move from these neutral scenarios to personal relationship conflicts, such as disputes over household chores or in-laws. By drawing "Triangle Pairs"—one unhelpful and one helpful alternative thought—couples trace how each interpretation plays out in their feelings and subsequent behaviours.

To reinforce the learning, the take-home exercise encourages partners to identify and discuss two stressful situations that arise during the week and sketch two triangles for each—one with their usual unhelpful thought and one with a more helpful alternative.

Key takeaway messages of the session include:

- While we cannot control most external situations, we can control how we think about them.
- Unhelpful thoughts are often interpretations, not absolute truths, and we can learn to question them.
- Shifting from an unhelpful to a helpful thought is a learned skill that reduces negative feelings and ultimately changes behaviour.

The Thinking Triangle is subsequently referenced in the curriculum as one of several tools for recognising and managing triggers of violence, alongside communicating assertively, balancing economic power, and reducing excessive alcohol use.

> ***'In Rwanda, we don't say exactly what we think; it's cultural. When someone asks how you are feeling, you say "I am fine," even when that means something else entirely. RWAMREC staff used to say that the Thinking Triangle is really deep. It untangles thinking in ways that fit our own cultural ways of expressing feelings. Learning to identify what you are actually feeling, that is really important in this context.'***
>
> ***—Indashyikirwa Practitioner***

WHAT THE AVAILABLE EVIDENCE SUGGESTS

A randomised controlled trial (RCT) of the 21-session Indashyikirwa couples' curriculum found that women in the intervention group were significantly less likely to report past-year physical and/or sexual IPV than those in the control group, with roughly a 55 percent lower risk. Men's reported perpetration also declined. The programme significantly reduced symptoms of depression among both women and men. These benefits were still evident two years after the programme began.[2]

APPROACH TWO: BREATH AND BODY-BASED REGULATION

Somatic approaches help participants reconnect with their bodies and interrupt physiological stress responses. These approaches are especially relevant in contexts where trauma has caused mind-body dissociation or where traditional verbal processing is difficult. The somatic techniques identified in this curriculum review focus on rhythmic breathing, grounding, and meditation. These techniques are brief, require no materials, and can be integrated into the opening or closing of any session.

Core elements for integration include body-scan and body-awareness exercises, which help participants identify where they hold physical tension or stress. This is paired with education on the physiological differences between shallow, stress-induced breathing and deep, calming breaths. Grounding techniques use sensory awareness to help participants return to the present moment.

Curriculum Spotlight: *I Can Say No* Curriculum –– Serbia
The I Can Say No curriculum, developed by the Autonomous Women's Centre (AWC) and Fundación INDERA, treats body connection as a prerequisite for learning. The core premise is that a person who is physiologically unsettled cannot fully absorb curriculum content, which can affect the quality of the entire group. By helping participants reconnect with their bodies at the start of a session, facilitators aim to improve the quality of the dialogue that follows.

Exercise: Breathe Your Own Breath
This five-minute exercise cultivates a sense of gentleness in the body through breath. Participants are invited to close their eyes and attend to the subtle sensations of breathing—for example, notice the curved shape of their eyelids as they close their eyes, and the temperature difference between the cool inhale and the warm exhale. They are invited to direct their attention to both the inner and outer experience of breathing, and, once they find a rhythm, to feel their lungs and ribcage expand on the inhale, and their chest settle on the exhale. Participants are encouraged to focus on the quality rather than the quantity of breath; facilitators avoid counting breaths.

Exercise: Journey Through the Body
This exercise reconnects participants with their physical selves by methodically moving their attention through the body. While seated or standing, participants are invited to place both feet flat on the floor and both palms flat on their thighs to feel the contact points. They are then asked to close their eyes while the facilitator slowly names different body parts, pausing after each time to allow participants to mentally travel to that part of the body and notice its sensations without moving it.

Both the breathing and body-scan exercises are intended to help participants reconnect with their physical selves, become aware of their own level of physiological disconnection, and experience what a different state of presence feels like. Even if they do not maintain that state beyond the session, they discover that such a state is possible.

The curriculum recommends starting each session with this type of simple breathing exercise. Returning to this practice at the beginning of each session reinforces the technique as participants build familiarity over time, making it increasingly accessible as a self-regulation tool they can use beyond the programme.

> *'Paying attention to their breath and body sensations was often new for the high school students (ages 14 to 19) participating in the programme. Students sometimes would laugh or feel awkward at the beginning, but reported feeling calmer and more relaxed after completing the exercise.'*
>
> *—I Can Say No Practitioner*

APPROACH THREE: RELAXATION TECHNIQUES AND STRESS MANAGEMENT

Structured relaxation practices help participants build a toolkit for managing stress and preventing emotional escalation, which is a direct pathway to reducing the risk of conflict and violence. Core elements to integrate include helping participants distinguish between positive, tolerable, and toxic stress and identify the negative consequences of prolonged toxic stress. These are accompanied by practical relaxation techniques, such as progressive muscle relaxation (PMR), which involves systematically tensing and releasing muscle groups; guided visualisation of a personal safe space; and the development of personalised coping kits.

Curriculum Spotlight: *Safe at Home*—Democratic Republic of Congo (DRC)
Developed by the International Rescue Committee (IRC) for couples and families in conflict-affected settings, Safe at Home addresses co-occurrence of IPV and child maltreatment in the DRC through a three-part curriculum for women, men, and families.

The women's and men's curricula both treat stress management and relaxation as important components of family wellbeing and violence prevention. They also distinguish between different types of stress to normalise stress as a part of life, help participants categorise their experiences, and distinguish its most harmful form:

- **Positive Stress:** Brief, normal, and part of healthy development (e.g. the stress of an exam or a medical procedure).
- **Tolerable Stress:** More severe and longer lasting but manageable with support (e.g. the loss of a loved one).
- **Toxic Stress:** Frequent, intense, or prolonged stress that overwhelms the nervous system (e.g. ongoing abuse, exposure to violence, accumulated economic hardship).

Facilitators explain that toxic stress not only affects the person experiencing it but also influences how they interact with their partner, respond to their children, and remain calm under pressure. By explicitly linking a caregiver's mental health to the safety and development of their children, as well as to overall family wellbeing, the programme increases participants' buy-in for stress management practices.

Relaxation Techniques
The women's and men's curricula teach that when stressors throw the nervous system out of balance, specific techniques can restore equilibrium by producing a "relaxation response"—a state of deep calm that is the physiological opposite of the stress response. Facilitators guide the group through several relaxation techniques designed to create a pause between a stress trigger and their reaction:

1. **Physical Interrupt:** Stepping away from a stressful situation.
2. **Cognitive Interrupt:** Counting backwards from 20 to zero to re-engage the rational mind.
3. **Abdominal Breathing:** Taking 10 slow breaths with the stomach visibly rising and falling to signal safety to the brain.
4. **Progressive Muscle Relaxation:** A "head-to-toe" sequence of systematically tensing and releasing muscle groups to relieve physical tension.
5. **Guided Visualisation:** Creating an imaginary safe space using sensory details (sounds, smells, touch) and with an identified companion for emotional support.

Participants are encouraged to practise these relaxation techniques together at home, transforming stress management into a shared protective factor for the household.

Because body-based and eyes-closed practices can occasionally activate trauma responses in conflict or violence-affected populations, facilitator training and supportive supervision are important components for safe delivery. Facilitators are trained to offer modifications, such as keeping eyes open, grounding attention on an external object,

and shortening the duration, while normalising opting out without explanation. They are also trained to provide referrals to appropriate services to respond to signs of distress or emotional overwhelm.

Beyond physical techniques, the curriculum emphasises that verbalising stress can act as a critical release valve for the nervous system. Facilitators guide participants through an analysis of the advantages and disadvantages of sharing their stresses, acknowledging that while talking can help process trauma and foster collective support, it also carries risks of judgement or emotional overwhelm. By mapping a support network of trusted friends, relatives, or peer groups, the programme helps participants move from isolated toxic stress to a model of shared resilience.

> ***'Guided visualisations was the most adapted activity—it was new to participants and was modified to be shorter. Participants' physical safety and assurance that they were in a safe space was an important step to support the activity. The programme was implemented in a conflict-affected setting, where rates of violence are reported to be high. The mapping of referral of mental health and psychosocial support (MHPSS) services before the programme began and linking participants to response services is key. Case management support is embedded as part of the design of this intervention.'***
>
> ***—Safe at Home Practitioner***

The Coping and Healing Kit Activity (Example Drawn from the Women's Curriculum[3])

The centrepiece of the session is a participatory activity where participants build a "kit" of stress-relief tools. Using a series of cards, each representing a different stress-relief resource, participants select those that resonate with them.

Card categories include:

- **Support network** — people you can visit or call who lift your spirits
- **Favourite places** — a place (past, present, or imagined) where you feel or once felt a great sense of peace and safety
- **Favourite books** — especially books that lift your mood
- **Gratitude list** — things you are grateful for
- **Reminders of other stress relievers** (e.g. doing a craft project)
- **Childhood favourite toys** — things you loved playing with
- **Best moments from the past** - reminders of wonderful memories
- **Drinks to enjoy** — non-alcoholic options available in the local environment
- **Comfort foods** — accessible foods that make you feel good
- **Relaxation exercises that work for you** (e.g. deep breathing, centring, muscle relaxation, or prayer)

This kit serves as a portable, personal reminder of participants' own resilience and provides a menu of options to choose from when they feel overwhelmed.

WHAT THE AVAILABLE EVIDENCE SUGGESTS

A pilot cluster RCT of the *Safe at Home* programme—delivered over six to eight months through weekly single-sex discussion groups and monthly family sessions—found significant reductions in violence within the home. Women in the programme had approximately 77 percent lower odds of experiencing IPV and 71 percent lower odds of using harsh discipline against their children than women in the comparison group. Men were also significantly less likely to report perpetrating IPV (approximately 74 percent lower odds). Their use of harsh discipline against children also declined, although that change was not significant. The programme produced further significant improvements in gender-equitable attitudes, power sharing within couples, lower acceptance of harsh discipline against both women and children (particularly among women), and a positive trend in parenting skills.[4]

Participation in the *Safe at Home* programme was also associated with significant improvements in women's mental health, although not men's.[5] Interestingly, a follow-up study found that mothers' mental health outcomes did not depend on their partners' initial gender attitudes or on how many sessions the men attended.[6] This suggests that the programme's gender-transformative content may directly benefit women's wellbeing on its own terms, rather than only through changes in couple dynamics. However, the researchers urge caution in interpreting these results because the study tracked only attendance rather than active engagement, and nearly half of the men's attendance data were missing and had to be estimated. In addition, the tool used to measure mental health had not been contextually validated for use in the DRC, and may not have fully captured how distress is culturally expressed in that setting.

APPROACH FOUR: TRAUMA AWARENESS

Psychoeducation about trauma—what it is, how it affects the brain and body, and what recovery can look like—is a powerful tool for reducing stigma, building empathy, and helping participants recognise signs of distress in themselves and others. By helping participants recognise that their "irrational" reactions are survival-based biological responses, programmes can shift the narrative away from blame. A trauma-informed approach is particularly important in conflict-affected and post-crisis settings, where trauma is a shared lived reality, and when supporting survivors of violence.

Core elements for integrating trauma awareness include providing clear definitions of different types of trauma, such as acute, chronic, and complex trauma, and explaining the brain's stress response, the 'fight, flight, or freeze' mechanism, which helps participants identify and normalise their experiences. It is also important to teach participants about sensory triggers, explaining how smells, sounds, and touch can activate the body's alarm system, and to promote resilience by emphasising the brain's inherent capacity for recovery.

Curriculum Spotlight: *Planim Save, Kamap Strongpela (PSKS)* — Papua New Guinea

Developed by the Nazareth Centre for Rehabilitation for Communities in Bougainville, Papua New Guinea—where the legacy of a decade-long civil conflict has left deep trauma across generations—the PSKS curriculum provides a comprehensive model for trauma-informed education. It is designed to help participants understand what has happened to them, why they respond the way they do, and that recovery is possible.

The centre, which also provides individual psychological counselling, uses peacebuilding and trauma healing as an entry point for working with communities to address violence against women and violence against children. The PSKS curriculum is designed for implementation with adult men and women of all ages. Throughout the curriculum, trauma is framed as an experience that overwhelms a person's capacity to cope rather than reflecting a character flaw or personal weakness.

The trauma session opens with a group brainstorm about what participants understand by the term 'trauma,' before offering clear definitions of different types of trauma:

- **Acute trauma:** A single traumatic event limited in time, such as a natural disaster or a sudden attack.
- **Chronic trauma:** Repeated traumatic events over time, such as ongoing domestic violence, physical abuse, or neglect.
- **Complex trauma:** Multiple or prolonged events, typically caused by adults entrusted with a child's care and beginning in early childhood.

The curriculum simplifies complex neurobiology into a three-layer model to explain how the brain functions under stress:

- **Thinking Brain (Cerebral Cortex):** Responsible for rational thought and problem-solving.
- **Emotional Brain (Limbic System):** Responsible for feelings and emotional memory.
- **Instinctual Brain (Brain Stem):** Controls automatic survival reactions, including fight, flight, and freeze responses.

Facilitators explain that during trauma or crisis, information bypasses the "Thinking Brain" and goes straight to the "Instinctual Brain." This explains why individuals—including those experiencing conflict or violence—may not act "rationally" because the "Thinking Brain" is temporarily not in charge. This explanation helps participants understand their own reactive behaviour and helps caregivers understand why children exposed to violence may behave in confusing or distressing ways.

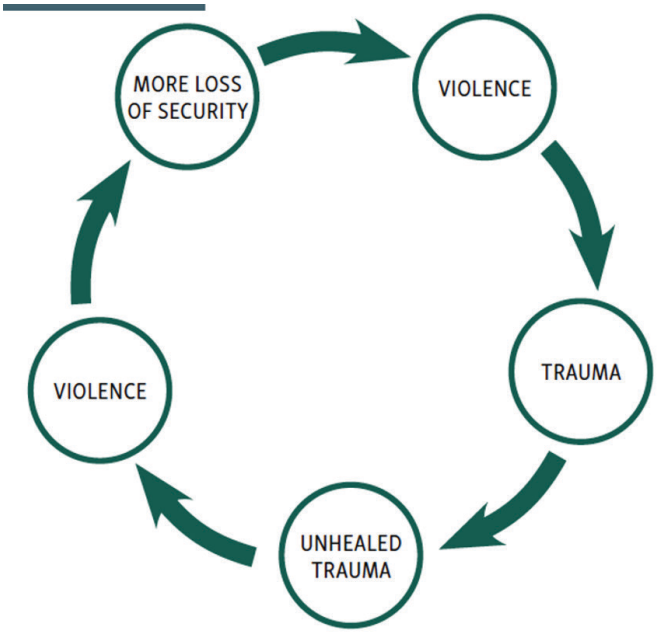
The curriculum presents a detailed list of trauma reactions, emphasising that these are normal reactions to abnormal events. Key reactions include:

- **Physical and Behavioural:** Changes in sleep patterns, nightmares, hyperactivity or under-activity, fatigue, hyperarousal, and health problems.
- **Emotional:** Fear and anxiety, guilt, shame, depression, emotional numbing, grief, anger and irritability, feeling isolated, inability to trust.

Facilitators emphasise that no one experiences every trauma reaction and that reactions can range from minor to severe. They also acknowledge that many people wait a long time before seeking help because they need space and time to determine how to respond to their trauma.

The curriculum also helps participants reflect on the cyclical relationship between trauma and violence: unhealed trauma can ignite conflict and violence, while violence, in turn, can deepen trauma, creating a cycle that is difficult to break without intentional support.

Figure 2: What is a Traumatic Event? From the PSKS Curriculum



Sensory Triggers and Trauma Memory

The *PSKS* curriculum devotes significant attention to how the five senses store and trigger trauma. Because the brain's smell-processing centre sits close to its emotion-processing centre, a specific scent can trigger a full-body fear response before a person consciously realises why. The same is true of the other senses: a particular song, texture, taste, or visual scene can activate the body's fear response even in a safe context.

The curriculum uses this understanding constructively. If sensory triggers can cause harm, they can also support healing. Facilitators help participants identify sounds, tastes, or textures that they associate with safety and positive memories and encourage them to draw on these within the group environment.

Resilience: Brain Plasticity

To establish hope and resilience as a core message, the curriculum uses the story of Phineas Gage—a railway worker who, in 1848, survived a 13-pound iron rod passing through his skull in an explosion and went on to live a relatively functional life for another 12 years. The story illustrates the brain's remarkable capacity for recovery and adaptation.

The core message delivered to every participant is that no child or adult is beyond repair. While the path to recovery varies depending on the duration and nature of the trauma, the curriculum asserts that recovery is possible for everyone, provided they have access to a safe, stable, and nurturing environment.

> ***'The simplest way I explain psychology to the people we work with is that it has to do with your mind or brain, and how the mind, the spirit or the soul, and body work together. These three levels are what make us human, and understanding how they work together to support you makes everything clear.'***
>
> ***—PSKS Practitioner***

RELATIONSHIP BETWEEN MENTAL HEALTH AND VIOLENCE

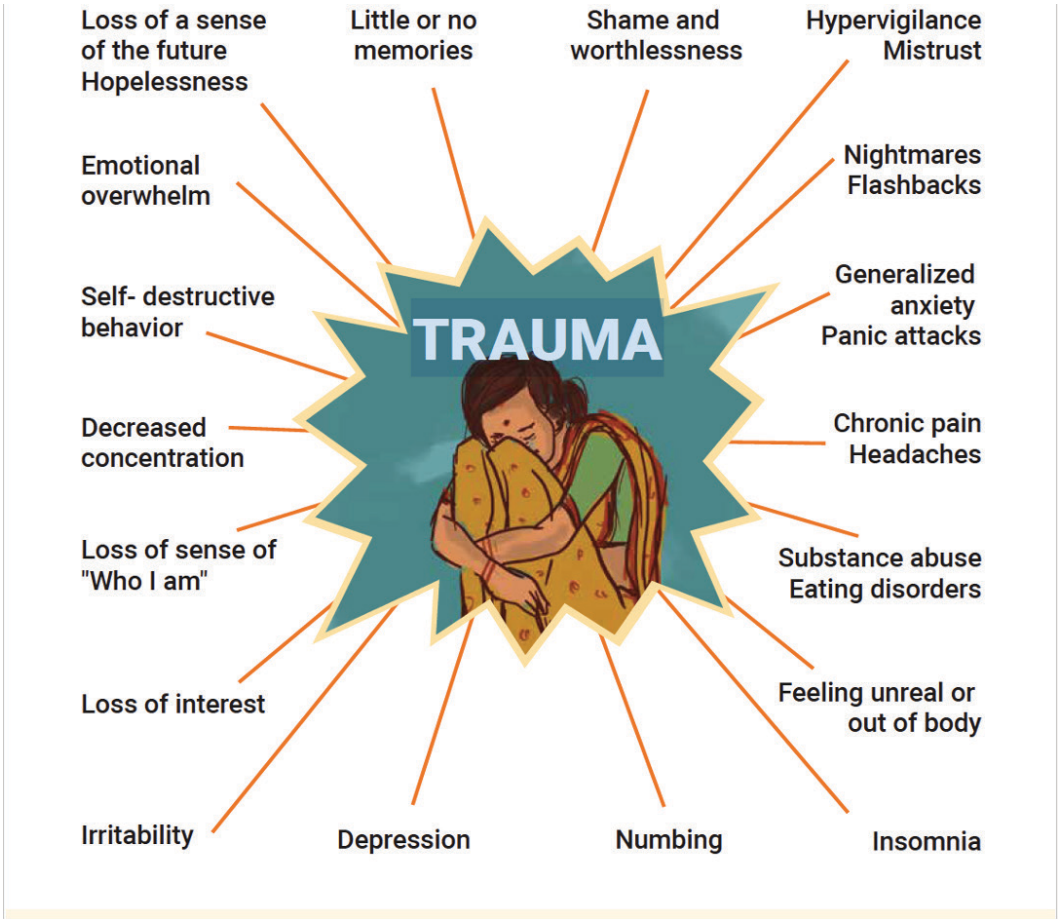
It is valuable to raise awareness of the relationship between poor mental health and violence through curricula. For instance, a curriculum developed by the Society for Nutrition, Education, and Health Action (SNEHA) to train non-specialist community workers and caseworkers in Mumbai, India, features a dedicated session that teaches how mental health and violence are closely related, as poor mental health can be both a risk factor for and a consequence of violence.

The session emphasises that:

- Many survivors of violence experience common mental health problems.
- Violence can lower survivors' self-esteem, cause emotional dysregulation, and generate psychosomatic symptoms such as depression and anxiety.
- Survivors experiencing prolonged violence may be at increased risk of suicide.

The session also emphasises that violence can cause trauma and that understanding its symptoms can help facilitators identify and respond to survivors of violence.

Figure 3. Poster of Symptoms of Trauma from the SNEHA Women's Group Curriculum in India.



APPROACH FIVE: PEER SUPPORT AND CO-COUNSELLING

Structured peer support helps create emotional safety within group-based programmes. By developing active listening skills and normalising help-seeking, programmes can create a self-sustaining environment of mutual care. Co-counselling—a practice where participants alternate between the roles of "client" and "counsellor"—is a highly effective, low-barrier approach that can be embedded into any group-based curriculum.

Core elements of an effective peer-support model include structured pair work that gives participants equal time to speak and listen, reinforcing the principle of mutual equality. This is underpinned by confidentiality agreements and the explicit teaching of non-judgemental active listening. Programmes should integrate regular peer check-ins into session openings or closings, allowing disclosure to deepen gradually as trust builds over the duration of the programme.

Curriculum Spotlight: *Sisters for Life* (South Africa) and *Samvedana Plus* (India)
The *Sisters for Life* Curriculum—originally developed by RADAR at the University of the Witwatersrand and delivered through the microfinance networks of the Small Enterprise Foundation (SEF) in rural South Africa—treats co-counselling not as a one-off activity but as

a recurring structural pillar. From the first session, participants are paired and remain with the same partner throughout the programme, building continuity, trust, and mutual accountability that deepen alongside the curriculum content.

Co-counselling is a form of peer psychological support where two people alternate between the role of client (speaking freely and exploring feelings) and counsellor (listening attentively without responding, judging, or problem-solving). The structure is flexible, and sessions can last as long as an hour for each participant or as little as five minutes.

The *Samvedana Plus* curriculum, which was co-led by the Karnataka Health Promotion Trust (KHPT) and Chaitanya AIDS Tadegattuva Mahila Sangha (CATMS) to support female sex workers facing high rates of IPV in northern Karnataka, India, adapted the co-counselling approach from *Sisters for Life.* The curriculum further explains the value of co-counselling by showing how it helps participants:

- **Process Emotions:** Move from suppressing difficult memories to expressing them in healing ways.
- **Manage Reactivity:** Harness emotions to inform their lives rather than becoming overwhelmed by them.
- **Improve Relationships:** Communicate feelings in ways that improve rather than damage their relationships.

This framing directly links co-counselling to IPV prevention including by managing emotional reactivity, building communication skills, and reducing relationship conflict.

> ***'I think co-counselling was an easy method for Samvedana Plus to adopt, as we had embedded this IPV intervention within an HIV prevention programme which already had a practice of hiring peers for outreach, and that practice was very acceptable to the women. Hence, it was easy to enhance the roles of the peer educators to provide counselling, as the practice of pairing was already there. It also helped that the peer counsellors lived in the same community, were similar ages, and were available for support and response. They were not going away after listening. That built confidence and trust.'***
>
> ***—Samvedana Plus Practitioner***

How the Structure Works in Practice

The power of this approach lies in its simplicity and in the clearly defined role of the 'Peer Counsellor': **to listen**. The listener does not offer advice or interpretations but simply provides full, attentive presence, creating a safe space for the speaker. Confidentiality is established as a foundational principle from the first session and reinforced throughout the programme. Trust is further strengthened by the peer counsellor's shared lived experience. Participants are heard by someone who genuinely understands their reality, deepening the sense of safety and connection.

Sessions do not have to address deep or difficult topics. Early sessions may simply involve sharing how participants are feeling in the moment or why they joined the programme. As participants become more comfortable with their partner, the depth and honesty of what is shared typically grow, and the value of the co-counselling process increases over time. Facilitators can use these pairs for multiple purposes throughout the curriculum:

1. **Session Check-ins:** 'How are you arriving today?' 'What has happened since we last met?'
2. **Reflecting on Take-Home Exercises**: 'How did you find practising the skills from the last session?'
3. **Processing Content:** Giving participants space to speak after a difficult session on trauma or violence.
4. **Accountability for Behaviour Change:** Discussing what they committed to trying in their relationships.

Facilitators do not need to direct what pairs discuss, as the structure itself creates space for whatever feels most important. This is one of the key advantages of embedding co-counselling throughout a curriculum: it provides regular mental health support without requiring additional sessions or clinical staff.

WHAT THE AVAILABLE EVIDENCE SUGGESTS

Sisters for Life is the curriculum component of the IMAGE intervention, which combined a 10-session gender and HIV training curriculum, followed by a community-mobilisation phase, with group-based microfinance for women in rural South Africa. A cluster RCT of the full IMAGE intervention found a 55 percent reduction in women's past-year experience of physical and/or sexual IPV compared with the control group.[7] The IMAGE trial did not measure mental health outcomes, and no evidence has been reported on the mental health impacts of *Sisters for Life* or the IMAGE intervention.

PROGRAMME DESIGN PRINCIPLES

Group-based IPV prevention programmes offer significant potential to strengthen mental health. Interviews conducted with mental health experts identified key programme design considerations for integrating these strategies into group-based curricula. While these principles apply broadly across programme contexts, the focus here is on how they can guide the integration of mental health content into existing group-based curricula—building on what programmes already do well rather than requiring wholesale redesign.

1. **Use Group Processes to Foster Connection**
   Group settings offer accountability, peer support, reduced isolation, and opportunities to learn from shared experiences. Programmes should prioritise group cohesion from the start, using opening rituals and community-grounding activities to build safety before diving into curriculum content.

2. **Combine Group-Based and Individual Support**
   Some participants may need individual preparation before group participation, especially those experiencing acute trauma and trauma-related symptoms, such as flashbacks or freezing. Effective programmes should establish clear referral pathways and use screening to identify participants who need one-on-one support before or alongside participation in the group programme.

3. **Consider Group Composition Carefully**
   Age, gender, socioeconomic status, trauma severity, and other factors can all affect group dynamics. Practitioners must be trained to navigate these dynamics, recognising that participants experiencing an acute mental health crisis may find a group setting re-traumatising. Establishing clear criteria for group participation can help ensure the safety of all participants.

4. **Invest in Lay Facilitators and Support Them**
   Lay counsellors and facilitators can effectively deliver activities that strengthen mental health, particularly relevant in contexts with limited access to mental health professionals. Choose facilitators with relevant lived experience and community credibility. Core facilitator skills, including empathy, genuineness, and reflective listening, matter as much as technical knowledge. Ensuring facilitators receive sufficient training, supportive supervision, and attention to their own mental health and wellbeing is critical.

5. **Adapt for Context and Culture**
   Evidence-based mental health strategies can be effective in a variety of settings following careful cultural adaptation. Using contextually relevant terms and language is important for reducing stigma and increasing accessibility. Practitioners should consider drawing on community-based and culturally grounded experiences and resilience-building practices to strengthen mental health and address trauma in ways that reflect participants' lived realities.

6. **Explore Digital Delivery Options**
   Group-based mental health strategies are increasingly offered through digital platforms, a trend accelerated by the COVID-19 pandemic and sustained because of the benefits organisations have observed in practice. Digital delivery can expand reach, reduce stigma, and increase accessibility for populations who may be reluctant to engage in person. As digital infrastructure improves across LMICs, practitioners should consider how digital, or hybrid delivery models, can influence the reach and impact of their programmes.

7. **Engage Men Intentionally**
   Addressing the gendered stigma and masculine norms that discourage men from seeking mental health care is vital for men's wellbeing and that of their families. When men have no safe way to process stress or depression, the effects often reverberate throughout the household. Interventions should confront the societal pressures tied to the provider role and help reduce the shame and purposelessness that can arise when men struggle to

fulfil these expectations. Addressing these pressures is a common feature of gender-transformative violence prevention programmes that engage men, including fatherhood interventions, some of which have significantly strengthened men's mental health.

8. **Create Pathways for Early Identification and Referral**
   Early identification and referral can reduce the severity of mental health symptoms and their related consequences. It is important to integrate screening into programme activities and ensure facilitators know how to appropriately respond to emotional distress and connect participants with local services. Facilitators should also be trained to follow up on referrals rather than assume participants will access services on their own.

RESOURCES AND FURTHER READING

- Stern, Erin, and Ruti Levtov. 2026. "Addressing Harmful Alcohol Use and Poor Mental Health: Missed Opportunities in Preventing Domestic Violence. Public Health: Special Edition on Addressing VAW as a Public Health Issue. doi.org/10.1016/j.puhe.2026.106223
- Doyle, Kate, Ruti Levtov, Lori Rolleri, Erin Stern, and Lori Heise. 2026. "A Scoping Review of IPV Prevention Curricula and Their Implementation in Low- and Middle-Income Countries: Implications for the Next Generation of Programs." *International Journal of Environmental Research and Public Health*, 23(8), 989. doi.org/10.3390/ijerph23080989
- Stern, Erin. 2025. *Improving Mental Health of Parents and Caregivers as a Strategy to Prevent Family Violence: What Does the Evidence Say?* Prevention Collaborative.
- Stern, Erin, and Ruti Levtov. 2025. *Opportunities for Innovation: Addressing Mental Health and Alcohol Use in IPV Prevention Curricula.* Prevention Collaborative.
- Stern, Erin. 2023. *Pathways Between Poor Mental Health and Intimate Partner Violence.* Prevention Collaborative.

Curricula Featured in This Brief:

- **Indashyikirwa Couples Curriculum** — Rwanda (CARE Rwanda and Rwanda Men's Resource Centre, [RWAMREC]). Available online: prevention-collaborative.org/wp-content/uploads/2021/08/Indashyikirwa-Couples.pdf
- **I Can Say No Curriculum** — Serbia (Autonomous Women's Centre, [AWC])
- **Safe at Home Women's Curriculum** — Democratic Republic of Congo (International Rescue Committee, [IRC]). Available online: gbvresponders.org/wp-content/uploads/2022/09/SAH_Module-2_Part-3_Womens-Curriculum.pdf
- **Safe at Home Men's Curriculum** — Democratic Republic of Congo (International Rescue Committee, [IRC]). Available online: gbvresponders.org/wp-content/uploads/2022/09/SAH_Module-2_Part-3_Mens-Curriculum.pdf
- **Planim Save, Kamap Strongpela (PSKS)** — Papua New Guinea (Nazareth Centre for Rehabilitation, [NCFR])

- **SNEHA Women's Group Curriculum** — India (Society for Nutrition, Education and Health Action, [SNEHA])
- **Sisters for Life** — South Africa (Intervention with Microfinance for AIDS and Gender Equity, [IMAGE])
- **Samvedana Plus** — India (Karnataka Health Promotion Trust, [KHPT]). Available online: strive.lshtm.ac.uk/sites/strive.lshtm.ac.uk/files/Facilitator%27s%20Guide%20for%20training%20female%20sex%20workers%20Reducing%20IPV%20and%20increasing%20condom%20usage%20in%20the%20HIV%20STI%20response_0.pdf

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REFERENCES

1. World Health Organization. 2022. *World Mental Health Report: Transforming Mental Health for All*. Geneva: World Health Organization. www.who.int/publications/i/item/9789240049338.
2. Dunkle, Kristin, Erin Stern, Sangeeta Chatterji, and Lori Heise. 2020. "Effective Prevention of Intimate Partner Violence through Couples Training: A Randomised Controlled Trial of Indashyikirwa in Rwanda." *BMJ Global Health* 5 (12): e002439. doi.org/10.1136/bmjgh-2020-002439
3. A version of this activity appears in both the women's and men's curricula, with card categories tailored to each group.
4. Falb, Kathryn L., Khudejha Asghar, Alexandra Blackwell, Simon Baseme, Martin Nyanguba, Danielle Roth, and Jean de Dieu Hategekimana. 2023. "Improving Family Functioning and Reducing Violence in the Home in North Kivu, Democratic Republic of Congo: A Pilot Cluster-Randomised Controlled Trial of Safe at Home." *BMJ Open* 13 (3): e065759. doi.org/10.1136/bmjopen-2022-065759
5. Balachander, Manya, Jean de Dieu Hategekimana Ndiyunze, Danielle Roth, Khudejha Asghar, Christine Bourey, and Kathryn L. Falb. 2024. "Effectiveness of a Family Violence Prevention Program on Mental Health Outcomes for Adult Men and Women in North Kivu, Democratic Republic of Congo: Insights from a Pilot Trial." *Cambridge Prisms*: Global Mental Health 11: e99. doi.org/10.1017/gmh.2024.98
6. Bhardwaj, Anvita, Rashelle J. Musci, Alexandra Blackwell, Danielle Roth, Yvonne Agengo, Joe J. Gallo, Sarah M. Murray, and Kathryn L. Falb. 2025. "Examining the Profile of Couples Attending a Violence Prevention Intervention: A Dyadic Latent Profile Analysis." *International Health Trends and Perspectives* 5 (3): 446–462.
7. Pronyk, Paul M., James R. Hargreaves, Julia C. Kim, Linda A. Morison, Godfrey Phetla, Charlotte Watts, Joanna Busza, and John D. H. Porter. 2006. "Effect of a Structural Intervention for the Prevention of Intimate-Partner Violence and HIV in Rural South Africa: A Cluster Randomised Trial." *The Lancet* 368 (9551): 1973–1983. doi.org/10.1016/s0140-6736(06)69744-4