Studies of Adversity, Resilience and Child Mental Health: Examples from Sierra Leone and Rwanda

Theresa S. Betancourt, Sc.D., M.A.
Assistant Professor, Department of Global Health and Population
Director, Research Program on Children and Global Adversity
François-Xavier Bagnoud Center for Health and Human Rights
Harvard School of Public Health
Overview

- Background: research on children, families and adversity
- Guiding frameworks
- Longitudinal Study of War-Affected Youth in Sierra Leone
- Mental health risks and processes of resilience in Rwandan children and families affected by HIV
- Implications for programming and policy
The Nature of War is changing with devastating consequences for Civilians

- Worldwide, over 1 billion children live in countries affected by armed conflict (UNICEF, 2008)
- Increases in regional and intra-national conflicts
  - non-state actors
  - little regard for international conventions
- Civilians, particularly young people, are often the most vulnerable
- Wars of destabilization; infrastructure is undermined
- Implications for survival, but also trajectory of development
Refugee Children and Adolescents in the US

- Resettlement of ~3 million refugees in the US since 1973, roughly half are children (Bureau of Population Refugees & Migration, 2010)

- Refugees and asylees face stress of isolation, socioeconomic disadvantage, cultural adjustment, language barriers, insecurity of legal status

- High levels of war-related trauma documented for refugee youth, with profound MH consequences (American Psychological Association, 2010).

- Challenges in treatment engagement and retention, very little services research
Research on Children, War & Mental Health

Children and War (Fred & Burlingham, 1943)

- Research on adults:
  - “concentration camp syndrome” (Eitinger, 1961)
  - war veterans “shell shock” (WW I, II, Vietnam)

- Focus on relationship between war-related trauma and post-traumatic stress disorder (PTSD)
  - Cambodian refugees: 50% developed PTSD (Kinzie, 1985)
  - Bosnian refugees: 25% PTSD and 17% depression dx (Weine, 1995)

- Criticism of PTSD focus- CONTEXT: There is no “post” ...in many of the wars children face around the world insecurity is constant

  - Available research is limited in its application to programs and policy
Resilience: “A construct representing positive adaptation despite adversity”
Hx of Resilience Research

- People who overcame situations normally associated with poor mental health and developmental outcomes
- Poverty, Socioeconomic Disadvantage (Werner)
- Mentally Ill Caregivers (Rutter)
- Abused and Neglected Children (Cicchetti)
- Children Exposed to Violence (Garbarino)
Resilience traits: traditionally refer to characteristics of the individual that helps them to achieve desirable emotional and social functioning despite exposure to considerable adversity.

Resilience as a process: “Resilient mental health outcomes”

Stress-Adjustment Paradigm
(Lazarus & Folkman, 1984)

Resources

• Individual Characteristics
  - i.e. coping skills
• Family Characteristics
  - i.e. social support
• Community Characteristics
  - i.e. belonging/connectedness

Mental Health Adjustment
Research Program on Children and Global Adversity (RPCGA): Goals

- Identify factors contributing to risk and resilience in children, families and communities facing adversity globally
  - focus on capacities, not just deficits

- Contribute to an evidence base on intervention strategies:
  - Contribute to closing the implementation gap
  - Develop and test high quality and effective services
Issues: Developmentally-informed Prospective/Longitudinal Research

Need:
- Developmental and ecological approaches
- Example re: war and children--Expansion of focus beyond the immediate crisis to include the post-conflict environment

Currently:
- Much research is cross-sectional
- Programming has not embraced a developmental perspective on children, adolescents and youth
- Intervention responses are short lived, even 6 months to a year in length
- Many intervention studies focus on individual children and fail to integrate the strength of extended families and communities; family-based interventions

Society:
- Political & historical context; cultural beliefs about reconciliation & healing

Community:
- Community acceptance/stigma, networks, social services, school opportunities

Family:
- Family support, caregiver functioning, family resources

Individual:
- Intelligence, temperament, age, gender, exposure to violence

Intensity, Duration & Meaning of Violence
- After Bronfenbrenner, 1979; Betancourt & Kahn, 2008
“Ethnographic studies demonstrate convincingly that concepts of emotions, self, and body, and general illness categories differ so significantly in different cultures that it can be said that each culture’s beliefs about normal and abnormal behavior are distinctive”

(Kleinman 1988, p.49)
1. Select or create questionnaire/select standard measure to adapt
   • Usually developed outside the local culture/situation
2. Translate into local language (no validity tests)
3. Individual interviews with survey
4. Determine need based on frequency of responses
5. Choice of problem and therefore intervention is based on quantitative results
6. Repeat individual surveys before and after intervention to assess program impact
Problems with Relying on Western Measures in Cross-Cultural Research

- **Cultural validity**: How closely concepts in a questionnaire match local concepts; Western/outside concepts may not apply locally

- **Unknown local concepts**: Are there important local issues/concepts unknown to us? How to include questions we don’t know we should be asking?

- **Translation problems**: Who translates? Translation-back translation methods inadequate, can result in semantic equivalence but real-world insignificance (i.e. lighting fires)

- **RISK**: Evaluations don’t accurately measure impact
Use a Mixed Methods Approach:
(qualitative + quantitative methods)
A Model for Designing and Evaluating Mental Health Services in Diverse Cultural Settings

Qualitative data informs assessment and intervention

- Identify important mental health constructs relevant to the context (qualitative inquiry)
- Use qualitative data to select, adapt, and create mental health measures and interventions; conduct validity study
- Implement culturally relevant intervention; evaluate with rigorous design

Apply lessons learned to new settings and intervention adaptations
SIERRA LEONE
Our Team & Collaborators

Harvard University
Theresa Betancourt
Julia Rubin-Smith
Ivelina Borisova
A’Nova Ettien
Robert Brennan
Kathy McGaffigan
Sidney Atwood
Sandra Zaeh
Brandi Harless

IRC
Marie de la Soudière
Catherine Wiesner
Jane Warburton
Jodi Nelson

Funding Support
USAID/DCOF
Lloyd Feinberg
John Williamson
Cathy Savino
USIP

In Sierra Leone
PRIDE
CAPS
Ministry of Social Welfare & Gender
DCI Sierra Leone
Moses Zombo
Musu Momoh
UNICEF SL
IRC Sierra Leone
CARITAS Freetown
Background

- Civil War 1991-2002
  - Massive population displacement (75%)
  - An estimated 15,000 to 22,000 children of all ages were associated with armed groups (McKay and Mazurana 2004)
  - National Committee for Disarmament, Demobilization and Reintegration (NCDDR) estimates that nearly 7,000 children were formally demobilized
  - Deliberate attempts to sever familial/community connections
  - 2002 peace accords
  - May 2001: over 4,250 formerly-abducted children “officially” demobilized and reintegrated

“Mohammad is crying,” drawing by former child soldier, Sierra Leone
The Return Home
Demobilization, Disarmament & Rehabilitation (DDR) 2002

Interim Care Centers
- Care and support through care centers
- Psychosocial activities to prepare for reintegration
- Family tracing/reunification; Community sensitization
- Community reintegration; follow-up support

*many youth returned home without formal DDR*
Research Design

**STUDY AIMS:** Identify **RISK & PROTECTIVE** processes in children’s psychosocial adjustment and community reintegration to inform programming and policy

- Qualitative and Quantitative data collection
- **To ground this research in the local cultural context**
- Sierra Leonean youth, community representatives, caregivers, social workers & local staff involved in questionnaire development & research design
- Local research team
- Social work follow-up

### Summary of Sample

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>ICC-served Group</td>
<td>N = 259</td>
<td>N = 151</td>
<td>N = 183</td>
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<tr>
<td>Comparison Group</td>
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<td>N = 58</td>
<td>N = 87</td>
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<tr>
<td>Self-reintegrated</td>
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<td>N = 127</td>
<td>N = 117</td>
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<tr>
<td>Totals</td>
<td>N = 395</td>
<td>N = 336</td>
<td>N = 387</td>
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</table>

**TOTAL N = 529**

Caretakers and/or significant others were also surveyed, with every effort made to interview the same caretaker at T3 that was interviewed at T2.
Measures

Demographics
Age, gender, SES collected via youth self-report

Psychosocial Adjustment (Depression, anxiety, hostility, prosocial behaviors/attitudes, confidence)
Oxford Measure of Psychosocial Adjustment (McMullin & Loughry 2004)

War Experiences (Deprivation, witnessing, victimization, perpetration)
Columbia Child War Trauma Questionnaire (Macksound & Aber 1996)

Community and Family Acceptance
Inventory of Socially Supportive Behaviors (Barrera and Ainlay 1983)
Family & Community Acceptance

Perceived Community Stigma
Everyday Discrimination Scale (Williams 1997)

Standard Scales of Depression, Anxiety, PTSD
Hopkins Symptom Checklist (Derogatis et al 1974)
Child Posttraumatic Stress Disorder Reaction Index (Pynoos et al 1996)

Access to Opportunities & Services
In School, Working
Post-War Adversities Index (Layne et al 1999)
Findings: War Experiences
(Betancourt et al, JAACAP 2010)

- Average age of abduction was 10.3 years (SD = 3.0)
- Average length of time with fighting forces was 4.1 years (SD = 2.4)
- Nearly all (97.7%) ex-RUF reported joining by force
- Participants had witnessed an average of 6.2 war-related violent events
- Violence exposures similar in males and females apart from sexual violence: 45% of female ex-RUF and 5% of male ex-RUF reported rape/sexual violence
- More than a quarter of the sample (26.9%, n=70) reported having killed or injured others during war
- 50% of former RUF youth reported being forced to use drugs or alcohol.

Painting of rebels using drugs, child in ICC Sierra Leone
Findings: Distribution of Main Variables

<table>
<thead>
<tr>
<th></th>
<th>Range of scale</th>
<th>T1 N=260^</th>
<th>T2 N=147^</th>
<th>T3 N=179^</th>
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</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td>15.13 (2.22)</td>
<td>17.41 (2.38)</td>
<td>21.75 (3.16)</td>
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<tr>
<td><strong>Outcomes</strong></td>
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<tr>
<td>Externalizing problems</td>
<td>0-48</td>
<td>19.32 (5.18)</td>
<td>20.24 (6.30)</td>
<td>18.52 (4.44)</td>
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<td>Internalizing problems</td>
<td>0-64</td>
<td>34.54 (7.64)</td>
<td>35.44 (7.63)</td>
<td>34.83 (6.45)</td>
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<tr>
<td>Adaptive/prosocial behaviors</td>
<td>0-72</td>
<td>58.27 (7.30)</td>
<td>59.29 (7.46)</td>
<td>57.42 (7.21)</td>
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<tr>
<td><strong>Post-conflict Hardships</strong></td>
<td></td>
<td></td>
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<tr>
<td>Stigma due to being a child soldier</td>
<td>0-18</td>
<td>...</td>
<td>2.50 (3.63)</td>
<td>1.61 (3.09)</td>
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<tr>
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<td>...</td>
<td>5.03 (3.54)</td>
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<tr>
<td><strong>Post-conflict Protective Factors</strong></td>
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<td></td>
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</tr>
<tr>
<td>Social support</td>
<td>0-84</td>
<td>...</td>
<td>...</td>
<td>41.32 (13.45)</td>
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<tr>
<td>Community acceptance</td>
<td>0-12</td>
<td>10.50 (2.55)</td>
<td>10.38 (2.41)</td>
<td>9.85 (2.71)</td>
</tr>
<tr>
<td>In school at time of assessment</td>
<td>--</td>
<td>165 (63.5%)</td>
<td>111 (75.5%)</td>
<td>86 (48.9%)</td>
</tr>
<tr>
<td>Working</td>
<td>--</td>
<td>...</td>
<td>...</td>
<td>43 (24.0%)</td>
</tr>
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</table>

Characteristics of the sample (former child soldiers in Sierra Leone) and distributions of main variables at each assessment reported as Mean (SD) or frequency (%).

^N=number of participants with complete data available at each time point who were included in the analyses.
### Longitudinal Analyses of Outcomes among Ex-CAAFAG (N= 260)

**Internalizing (anxiety & depression)**

#### Baseline higher internalizing:
- Longer with armed group
- Victim of rape
- Stigma

#### Increasing internalizing:
- Young age at time of first involvement
- Many daily hardships

#### Protective factors
- Higher community acceptance at baseline
- Community acceptance improves over time

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<table>
<thead>
<tr>
<th></th>
<th>War experiences</th>
<th>Post-conflict hardships</th>
<th>Protective Factors</th>
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<tr>
<td><strong>Baseline</strong></td>
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<tr>
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<td>34.94***</td>
<td>34.94***</td>
<td>35.01***</td>
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<td>0.34+</td>
<td>0.29</td>
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<td>N of years in fighting forces</td>
<td>0.56*</td>
<td>0.55*</td>
<td>0.42+</td>
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<tr>
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<td>0.22</td>
<td>0.12</td>
<td>0.05</td>
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<td>Killed/injured others in war</td>
<td>0.26</td>
<td>-0.37</td>
<td>-0.28</td>
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<td>Victim of rape/sex assault</td>
<td>4.60*</td>
<td>4.25+</td>
<td>4.34*</td>
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<tr>
<td>Stigma of being child soldier</td>
<td>1.22**</td>
<td></td>
<td>0.89</td>
</tr>
<tr>
<td>Daily hardship score</td>
<td>-0.26</td>
<td>-0.24</td>
<td></td>
</tr>
<tr>
<td>Social support</td>
<td></td>
<td></td>
<td>0.29</td>
</tr>
<tr>
<td>Working, not in school</td>
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<tr>
<td>Cumulative school attendance</td>
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<td>-0.1</td>
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<tr>
<td>Avg. community acceptance</td>
<td></td>
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<td>-1.21**</td>
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#### Change over time

<table>
<thead>
<tr>
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<td>Intercept</td>
<td>0.3</td>
<td>0.47</td>
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<td>Age first involved in fighting</td>
<td>-0.35*</td>
<td>-0.29*</td>
<td>-0.27+</td>
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<td>N of years in fighting forces</td>
<td>-0.33+</td>
<td>-0.26</td>
<td>-0.21</td>
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<tr>
<td>Witness violence</td>
<td>-0.04</td>
<td>-0.02</td>
<td>0.02</td>
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<td>Killed/injured others in war</td>
<td>1.22+</td>
<td>0.47</td>
<td>0.34</td>
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<tr>
<td>Victim of rape/sex assault</td>
<td>-0.15</td>
<td>-0.39</td>
<td>-0.38</td>
</tr>
<tr>
<td>Stigma of being child soldier</td>
<td>0.26</td>
<td>0.22</td>
<td></td>
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<tr>
<td>Daily hardship score</td>
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<td>1.38***</td>
<td>1.33***</td>
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<tr>
<td>Social support</td>
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<tr>
<td>Working, not in school</td>
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<td>-0.22</td>
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**In school at time of assessment**

<table>
<thead>
<tr>
<th></th>
<th>War experiences</th>
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<tbody>
<tr>
<td>Intercept</td>
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<td>0.6</td>
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**Level of community acceptance at time of assessment**

<table>
<thead>
<tr>
<th></th>
<th>War experiences</th>
<th>Post-conflict hardships</th>
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<tbody>
<tr>
<td>Intercept</td>
<td></td>
<td></td>
<td>-0.86*</td>
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### Externalizing War experiences, Post-conflict hardships, Protective Factors

<table>
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<th>Baseline</th>
<th>Externalizing (hostility)</th>
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<td>19.67***</td>
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<tr>
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<tr>
<td>N of years in fighting forces</td>
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<tr>
<td>Witness violence</td>
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<tr>
<td>Killed/injured others in war</td>
<td>0.66</td>
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<tr>
<td>Victim of rape/sex assault</td>
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<tr>
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<td>0.89+</td>
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<tr>
<td>Daily hardship score</td>
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<tr>
<td>Social support</td>
<td></td>
</tr>
<tr>
<td>Working, not in school</td>
<td></td>
</tr>
<tr>
<td>Cumulative school attendance</td>
<td></td>
</tr>
<tr>
<td>Avg. community acceptance</td>
<td></td>
</tr>
</tbody>
</table>

| Change over time | | |
| Intercept | -0.29 | -0.22 | -0.09 |
| Age first involved in fighting | 0.09 | 0.11 | 0.12 |
| N of years in fighting forces | 0.04 | 0.07 | 0.1 |
| Witness violence | 0.29 | 0.29 | 0.22 |
| Killed/injured others in war | 1.16+ | 0.93+ | 0.90+ |
| Victim of rape/sex assault | -0.64 | -0.7 | -0.78 |
| Stigma of being child soldier | | -0.01 | 0.03 |
| Daily hardship score | | 0.51+ | 0.4 |
| Social support | | 0.38 | |
| Working, not in school | | 1.15+ | |

| In school at time of assessment | | |
| Intercept | | 1.01 |

<p>| Level of community acceptance at time of assessment | | |
| Intercept | | -1.08*** |</p>
<table>
<thead>
<tr>
<th></th>
<th>War experiences</th>
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<tbody>
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<td><strong>Baseline</strong></td>
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<tr>
<td>Intercept</td>
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<td>59.33***</td>
<td>58.80***</td>
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<td>N of years in fighting forces</td>
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<td>-0.19</td>
<td>0.06</td>
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<tr>
<td>Witness violence</td>
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<td>-0.4</td>
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<tr>
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<td>1.93+</td>
<td>1.53</td>
<td>1.24</td>
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<td>Victim of rape/sex assault</td>
<td>0.58</td>
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<td>0.83</td>
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<td>0.91</td>
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<tr>
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<td>0.59</td>
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<td>Social support</td>
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<td>-0.03</td>
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<td>0.95</td>
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<tr>
<td>Cumulative school attendance</td>
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<td>1.50**</td>
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<tr>
<td>Avg. community acceptance</td>
<td></td>
<td></td>
<td>1.69*</td>
</tr>
<tr>
<td><strong>Change over time</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>-0.89**</td>
<td>-0.95**</td>
<td>-0.55</td>
</tr>
<tr>
<td>Age first involved in fighting</td>
<td>-0.12</td>
<td>-0.15</td>
<td>-0.23+</td>
</tr>
<tr>
<td>N of years in fighting forces</td>
<td>-0.06</td>
<td>-0.09</td>
<td>-0.15</td>
</tr>
<tr>
<td>Witness violence</td>
<td>0.18</td>
<td>0.26</td>
<td>0.03</td>
</tr>
<tr>
<td>Killed/injured others in war</td>
<td>-2.60***</td>
<td>-1.88*</td>
<td>-1.29+</td>
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<tr>
<td>Victim of rape/sex assault</td>
<td>0.34</td>
<td>0.63</td>
<td>0.13</td>
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<td>-0.91**</td>
<td>-0.61+</td>
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<td>0.03</td>
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<td>Social support</td>
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<td></td>
<td>0.93*</td>
</tr>
<tr>
<td>Working, not in school</td>
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<td></td>
<td>0.38</td>
</tr>
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</table>

**In school at time of assessment**

| Intercept                     | 2.69***         |

**Level of community acceptance at time of assessment**

| Intercept                     | 1.93***         |
VIGNETTES: LINKING THE STATISTICS TO LIFE STORIES
Sahr

- Male, 17 years old and living in provinces
- Abducted by RUF at age of 7 years
- Spent 4 years with RUF witnessing massacres, bombings, amputations and shootings. Tasked with spying and information gathering.
- Fed food laced with drugs by RUF
- After war, first spent 2 years with foster mother, then reunited with mother, grandmother and uncle
  - Mother and grandmother love him dearly: “He came back to us because he loved us,” they say.
  - Mother struggled with mental health problems (likely depression)
- In following years, Sahr had difficulties reintegrating with community
  - Considered to be “troublesome” by uncle
  - Little community acceptance (community members called him names, beat him in attempt to “correct” him)
  - Stole things
- He also had difficulty coping with everyday stress
- He dropped out of school and remained unemployed
- His mother says he was an agreeable boy before being abducted. Now he sometimes threatens others by pulling a knife
- Mother didn’t know of his whereabouts for several years
How is Sahr’s experience reflected in the data?

**Psychosocial outcomes at Waves I, II, and III - Sahr**

- **Internalizing**
  - Wave I: [Internalizing score for Wave I]
  - Wave II: [Internalizing score for Wave II]
  - Wave III: [Internalizing score for Wave III]

- **Externalizing**
  - Wave I: [Externalizing score for Wave I]
  - Wave II: [Externalizing score for Wave II]
  - Wave III: [Externalizing score for Wave III]

- **Adaptive**
  - Wave I: [Adaptive score for Wave I]
  - Wave II: [Adaptive score for Wave II]
  - Wave III: [Adaptive score for Wave III]
Amina

- Female, 23 yrs old, living in provinces
- Abducted at age 10
- Spent 2.5 years with RUF as a supply carrier and cook. While with the RUF, she was beaten frequently and now has lasting deformity. She was also forced to take drugs and commit violence.
  - Took part in amputations
- Went through demobilization & reintegration program, now lives with mother, grandmother, and her child (has no partner).
  - Received a lot of comfort and understanding from her mother who is a teacher
- Faced difficulties on first return to community
  - Experienced torment after returning
  - Called a rebel by other students
  - Has adjusted well over time
  - Reports no community problems
  - Mother says most do not know she was with RUF
  - Feels good about the future
- Continues school and is a determined student
How is Amina’s experience reflected in the data?

Psychosocial outcomes at Waves I, II, and III - Amina

- Mean RUF (Female)
- Amina

Wave I | Wave II | Wave III
---|---|---
Internalizing | | |
Externalizing | | |
Adaptive | | |
Summary

- Many ex-CAAFAG stable; but **unmet mental health needs** remain

- Poor outcomes greatest in those with an accumulation of **war-related and post conflict risk factors**:
  - War Experiences: rape, participation in injuring/killing others
  - Post-conflict Experiences: stigma (manifest differently for boys & girls), daily hardships

- Predictors of good psychosocial adjustment include **variables that can be leveraged via interventions**:
  - Community acceptance/reducing stigma
  - Social support
  - School access
Community Association for Psychosocial Support (CAPS)
The Youth Readiness Intervention

Research Program on Children and Global Adversity
FXB Center for Health and Human Rights
Harvard School of Public Health

Sierra Leone Youth Readiness Intervention Facilitator’s Manual

Interventionist Manual

2012
Youth Readiness Intervention

- Sierra Leone is currently experiencing rapid development
- The World Bank has pledged US$20 million for Youth Employment Support (YES)
- Significant growth in the private sector
- Result in creation of job opportunities
- However, large subgroups of youth are unable to benefit from current education and vocational training programs. Opportunities go to the well-connected and high functioning
- More troubled youth may most need such opportunities to get back on track
The Youth Readiness Intervention: Addressing the Past, Facing the Future

- **Evidence-based components integrated** to address intervention targets identified by longitudinal study; multi-problem youth (comorbidity)
- A **group-based** model designed to be administered by a **wide range of providers**
- Focuses on **increasing adaptive skills and prosocial behaviors** of youth who are managing stressors due to past traumatic experiences
- Furnishes youth with **strategies for coping, emotional regulation and problem solving**
- Drawn from work with survivors of complex trauma who continue to demonstrate distress and impairment in the post-conflict setting
- **Engages families and communities** to support care for vulnerable youth
YRI Theory of Change

**Stabilization**
- Psychoeducation
  - Alleviates isolation & normalizes responses
  - Reduces anxiety
- Relaxation
  - Combats physiological arousal caused by mental health problems

**Integration**
- Cognitive Restructuring
  - Increases empowerment
  - Improves depression & anxiety symptoms
  - Reduces anger
- Behavioral Activation
  - Encourages sense of self-efficacy
  - Increases motivation

**Connection**
- Communication & Interpersonal Skills
  - Increases ability to navigate post-conflict environment
- Problem-solving & Working towards life goals
  - Improves ability to address life challenges
  - Improves interpersonal skills
Making the Transition from the Evidence Base to Local Relevance

- These treatments have robust evidence of effectiveness in the US and UK

- Paucity of data in low and middle income countries, particularly war-affected regions
Mixed Methods Process of Intervention Development & Cultural Adaptation
Kono & Freetown

- **Process**
  - **Focus groups**
    - War-affected Youth
    - Caregivers, elders, community members
  
  - **Key Informant interviews**
    - Mental health professionals, youth serving organization staff, educators, health care workers, religious & community leaders
    - Key stakeholders in Sierra Leone government Ministries
  
  - **Community Advisory Board**
    - All input is directed at adapting the evidence-based modules to develop the group intervention manual

- **Result**
  - **Preliminary YRI intervention manual**
    - Including session outlines, exercises and activities, and a group facilitator training material which can be piloted in Sierra Leone

  - Ongoing Process!
STAGE A: Kapu sense noh kapu wod

EDUCATION & OUTREACH

• Wan tik broom noh dae sweep (Community Meeting)
• Leh we join togedah (Invitation to join & screening)
• Fambul tik ken ben, but enoba broke / Tit en tong mus jam (Family Focus)

STAGE B: Yu get pawa for cheng yu layf

SKILL BUILDING FOR SUCCESS – YOUTH GROUP SESSIONS

1. Kapu sense, noh kapu wod (Engagement)
2. Sabi noh get worri (Education)
3. Rain noh dae fodom nah wan man domot (Beliefs Bodies Behaviors)
4. If yu tek tem kill anch, yu go see im gut (Problem Solving)
5. Put u yai dong so u go si u nos (Relaxation & Behavioral Activation)
6. If yu was yu han fayn yo go it wit big pipul (Interpersonal Skills)
7. If yu noh kno usiae yu komot, yu for kno usiae yu dae go (Review)
8. Good wod pull good kola (Focus on the Positive)
9. Tinap no dae stop u fo dance (Relapse Prevention)
10. Tem gor gladi en go befoe (Celebration)
Clinical Training:

Importance of strong local partnerships.
Next Steps

**Pilot feasibility study** of the YRI, cross-over design, 128 youth stratified by age and gender

**Future Randomized controlled trial** to examine YRI effectiveness under task shifting to Community Health Workers (CHWs)

**Scaling up:** Integration of the YRI within employment and educational programs to support successful transitions
The Family Strengthening Intervention (FSI) in Rwanda

Mental Health and Resilience in Children Affected by HIV/AIDS in Rwanda

Theresa S. Betancourt
Anne Stevenson, Christina Mushashi,
and Charles Ingabire

Harvard School of Public Health/FXB Center for Health and Human Rights

Partners in Health
Rwanda is characterized by compounded adversities: 1994 genocide, the HIV/AIDS epidemic, extreme poverty (UNAIDS, 2008; Kayirangwa et al., 2006)

- Damaged family networks abraded by genocide and HIV/AIDS cause dramatic shifts of responsibilities between parents and children (Doku, 2009; Bauman et al., 2006; Lester et al., 2006)
Background: Children Affected by War and other adversity in Rwanda

- Children who have lost caregivers are at increased risk of depression & PTSD (Dyregrov et al., 2000).

- Youth heads of households display higher levels of depression, social isolation & emotional distress (Boris et al., 2006).

- Social and economic hardships pose further risks to mental health (Bachmann & Booysen, 2003; Nampanya-Serpell, 2000; Brouwer et al., 2000)
HIV is a family illness

For HIV-affected families at high risk for mental health problems, **preventive mental health interventions** are needed (Denison et al., 2009; Biddlecom et al., 2009; Bell et al., 2008)

Prevention can be **integrated into routine HIV testing and treatment** (Chatterjee et al., 2008)

**Strengths-based preventive programs** that enhance natural resources have demonstrated effectiveness in large-scale trials (Beardslee et al., 1998, 2003, 2006; Lee et al., 2009)
preliminary research

- Completed **2 qualitative studies**
  - Used Free Listing and Key Informant techniques
  - Identified 6 local mental health problems (Betancourt et al., 2011)
  - Identified 5 local protective processes (Betancourt et al., 2011)

- Developed and **validated mental health measures**
  - Investigated how closely local concepts matched Western concepts
  - Adapted and carefully translated assessments
  - Evaluated reliability and validity through rigorous design
Syndromes:

- Agahinda kenshi
- Kwiheba
- Guhangayika
- Umushiha
- Uburarara

Protective Processes:

- Kwihangana
- Kwigirira icyizere
- Ubufasha
- Kwizerana
- Uburerere bwiza


The FSI-R: An adaptation of the Family-Based Preventive Intervention (FBPI)

- **Evidence-based intervention** (National Registry of Effective Programs & Practices) originally developed for offspring of depressed caregivers by Dr. William Beardslee

- Designed to be administered by a **wide range of providers**

- As a **family-based** preventive model, it focuses on identifying and enhancing resilience and communication in families who are managing stressors due to parental illness

- Good “fit” for the setting and context of HIV in Rwandan families

*This partnership is the first effort to adapt this evidence-based preventive intervention to the context of SSA and HIV/AIDS-affected families*
Risk Factors

- Misinformation and Fear of HIV/AIDS
- Foreshortened Sense of Future
- Poor Communication among Family Members
- Family Social and Economic Stress

Core Components of the Intervention

- Psychosocial Education about HIV/AIDS and Trauma
- Establish the Family Narrative
- Improved Family Communication & Parenting Skills
- Outline Problem-Solving Skills & Links to Resources

Outcomes

- Improved Parent-Child Relationships and Diminished Risk of Mental Health Problems in Children

Core Components of the Family-Strengthening Intervention for Rwanda (FSI-R)
Intervention Development in low Resource Settings

- Eventual scale-up always in mind
  - Community-based
  - Portability
  - Lay clinicians
- Tiered supervision structure
  - Clinical Supervisors become trainers
- Filling gaps
  - Lack of existing community-based mental health services
In Conclusion..

- Reframing “child mental health interventions”: must consider the child in context and target resilient outcomes as the goal.
- Need to look beyond the individual to family, school and community protective influences on child mental health.
- Should identify modifiable risk and protective processes that may be leveraged by intervention.
“I think about what I have been through and this gives me more determination to do well in life.”

19 year-old male former child soldier from Kono (just promoted to his final year of secondary school)
Thank you!
What are the Implications of an ecological approach for your own clinical work?: Vignette

- Fatima, 10 year old girl from Afghanistan
- referred by mother for a psychological assessment at a torture treatment center
- mom concerned about the traumatic events that her daughter had experienced in her home country and in flight to the United States
- “worried about everything that she has seen and experienced”; “she doesn’t let herself be a child”
- “Fatima needs a mother figure”
1. Where do you see resilience/vulnerability factors in this case? At the level of the child? The family? The community? What are the implications for treatment planning?

2. What are the resources/vulnerabilities/opportunities that an organization would need to consider (i.e. staff capacity? Links to other services?) What are some capacity building needs/suggestions for working with such populations?

3. What roadmap would you propose for programmatic decisions? Where are the leverage points, assets to build on in intervention planning? What would be key elements of your treatment plan in this case?